North East London
Integrated Care Board

NHS North East London Integrated Care Board

29 March 2023, 1.30pm – 4.30pm; Guildhall, City of London, EC2V 7HH

Agenda

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	1.30	Chair		
1.1	Declaration of conflicts of interest			Attached	Note
1.2	Minutes of the meeting held on 25 January 2023			Attached	Approve
1.3	Matters arising			Verbal	Note
1.4	Actions log			Attached	Note
2.0	**Resident story**	1.35			Discuss/ note
3.0	**Chair and chief executive reports**				
3.1.	Chair's report	1.55	Chair	Attached	Note
3.2.	Chief executive officer's report	2.00	ZE	Attached	Approve
4.0	**Strategy**				
4.1.	Joint forward plan – March submission	2.05	JM	Attached	Approve
4.2.	Financial Strategy	2.15	HB	Attached	Approve
5.0	**Quality**				
5.1.	Deep Dive: Urgent and Emergency Care	2.30	PG	Attached	Note
	Comfort break – 10 mins	2.50			
6.0	**Pharmacy, optometry and dentistry services delegation programme**	3.00	JM	Attached	Approve
7.0	**Joint working model with NHSE for Specialised Services for 2023/2024**	3.10	PG	Attached	Approve
8.0	**Finance and performance overview**	3.20	HB	Attached	Note
9.0	**Governance**				
9.1.	Board Assurance Framework	3.30	CP	Attached	Discuss/note
9.2.	Committee exception reports for information • Executive Committee exception report • Audit and Risk Committee exception report • Workforce and Remuneration Committee exception report	3.40	ZE CPatel DH	Attached Attached Attached	Note Note Note

	Item	Time	Lead	Attached/ verbal	Action required
	• Quality, Safety and Improvement committee exception report • Finance, Performance and Investment committee exception report • Population Health and Integration committee exception report		DJ/IR HB Chair	Attached Attached Attached	Note Note Note
10.0	**Board forward plan**	3.45	Chair	Attached	Discuss
11.0	**Questions from the public**	3:50	Chair	Verbal	Discuss
12.0	**Any other business and close**	4.05	Chair	Verbal	Discuss
Date of next meeting: 31 May 2023					

Purpose, priorities, aims and our decision-making principles

Our agreed ambition, which is also that of North East London Health and Care Partnership which we are part of, is that "**We will work with and for all the people of north east London to create meaningful improvements in health, wellbeing and equity**".

To help guide our work, together partners have agreed **four priorities, or joint action areas,** where we want to create measurable change, which will create key outcomes for our system and place strategies. These are:

1. **Employment and workforce** – to work together to create meaningful work opportunities and employment for people in north east London now and in the future.
2. **Long term conditions** – to support everyone living with a long-term condition in north east London to live a longer, healthier life and to work to prevent conditions occurring for other members of our community.
3. **Children and young people** – to make north east London the best place to grow up, through early support when it is needed and the delivery of accessible and responsive services.
4. **Mental health** – to transform accessibility to, experience of and outcomes from mental health services and well-being support for the people of north east London.

Partners also agreed the following design or operating principles for our system:

Improving quality and outcomes: Individually and together, we will continuously improve access, experience and outcomes for and with our residents, with a specific focus on delivering integrated care in the neighbourhoods where our residents live and work. We will seek to learn together and from international best practice to continuously improve quality, to reinvent our ways of working and better secure our outcomes.

Securing greater equity: We will resolutely tackle inequality in outcomes and experience for our residents and staff, harnessing the diversity of our north east London experience to create better and more responsive solutions and utilising our combined resources to tackle the causes of inequality. We embrace the right of our residents to meaningfully participate, as an equal part of our team, benefiting from the strengths that they bring as individuals and communities.

Creating value: We will transparently work with our residents and staff to secure the maximum, sustainable benefit from our physical, digital and financial resources, repurposing what we have, reducing waste and taking care of our environment. Critically we will support and enable our most important resource, our staff, to reach their potential, enjoy work and be able to effectively contribute to our vision.

Deepening collaboration: We will work in meaningful partnership towards shared goals, holding each other to account for the commitments we have made to each other and to our residents. We will set resident interest and the common good as our

defining success measure and we will support our staff to lead and deliver across organisational boundaries. Our key collaboration will be with our residents, who will drive and co-deliver and evaluate the outcomes of our partnership

The four aims of our integrated care system

- 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

Our decision-making principles

ICB board members have agreed a set of principles for decision making as follows:

- Always put the best interests of all the residents of north east London first within a culture where our residents are our partners and co- production is universally applied
- Proactively tackle health inequities in access, experience and outcomes. Demonstrably consider the equality, diversity and inclusion implications of the decisions we make
- Bring our experience and sector perspective, rather than representing the individual interests of any member organisation or place over those of another.
- Be open and transparent, including when we have challenges, and ensure our communities can hold us to account for delivery. Though this provide constructive challenge, but always remain ‘solution-focused’
- Create a culture of creativity, innovation, improvement and inspiration, enabling transformation for better outcomes with our people and communities
- Be brave and ambitious for our communities, while ensuring we are grounded and realistic. In doing this consider risks and mitigations carefully, but not be risk averse where we believe we can make improvements for local people
- Support distributed leadership and decision making – close to people – being outcome focused whilst assuring performance.
- Demonstrate and enable collaboration, mutual accountability, shared learning, embedding of best practice and joint development.
- Secure the best value and benefit from our collective resources, maximising productivity.

NHS North East London

North East London Integrated Care Board Register of Interests

- Declared Interests as at 22/03/2023

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Andrew Blake-Herbert	Chief Executive; London Borough of Havering	Havering ICB Sub-committee Havering Partnership Board ICB Board ICB Workforce & Remuneration Committee ICS Executive Committee	Financial Interest	London Borough of Havering	Employed as Chief Executive	2021-05-01		Declarations to be made at the beginning of meetings
Cha Patel	ICB Board Non-Executive Member	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee	Financial Interest	Eastlight Homes	Member of Board; Chair of Audit and Risk; member of Finance and Performance Committee	2022-12-12		
			Financial Interest	Community Health Partnerships	Member of Board; member of Audit Committee; Chair of Finance, Investment and Systems Committee	2022-12-12		
			Financial Interest	Igloo Consultants Limited	Director of family owned consultancy business	2022-12-12		
Diane Herbert	Non-Executive Member	ICB Board ICB Workforce & Remuneration Committee ICB Quality, Safety & Improvement Committee	Non-Financial Professional Interest	Hertfordshire Partnership University Foundation Trust (HPFT)	Non executive director	2019-05-19		
Diane Jones	Chief Nurse	ICB Board Clinical Advisory Group ICB Quality, Safety & Improvement Committee ICS Executive Committee Primary care contracts sub-committee	Non-Financial Professional Interest	Royal College of Nursing (RCN)	Professional membership	2020-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of Midwives (RCM)	Professional membership	1994-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Nursing & Midwifery Council (NMC)	Professional membership	1992-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Clinical Senate	Member	2017-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Homerton Hospital	Midwife (honorary contract)	2015-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Group B Strep Support (GBSS)	Director and Trustee	2020-01-01		Declarations to be made at the beginning of meetings

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Dr Mark Rickets	Primary Care ICB board representative	ICB Board Clinical Advisory Group ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Workforce & Remuneration Committee	Financial Interest	Nightingale Practice (CCG member practice)	Salaried GP	2022-02-02		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	GP Confederation	Nightingale Practice is a member	2022-02-02		Declarations to be made at the beginning of meetings
			Indirect Interest	Health Systems Innovation Lab, School Health and Social Care, London South Bank University	Wife is a Visiting Fellow	2022-02-02		Declarations to be made at the beginning of meetings
			Financial Interest	Homerton University Hospital NHS Foundation Trust	Non-executive Director	2022-02-02		Declarations to be made at the beginning of meetings
			Indirect Interest	Point of Care Foundation	Wife is an Associate with the Point of Care Foundation whose work includes being a mentor for NEL ICS Schwartz Rounds	2022-03-01		Declarations to be made at the beginning of meetings
Dr Paul Francis Gilluley	Chief Medical Officer	ICB Board Clinical Advisory Group ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Primary care contracts sub-committee	Non-Financial Professional Interest	British Medical Association	I am a member of the organisation.	2022-07-01		
			Non-Financial Professional Interest	Royal College of Psychiatrists	Fellow of the College	2022-07-01		
			Non-Financial Professional Interest	Medical Defence Union	Member	2022-07-01		
			Non-Financial Professional Interest	General Medical Council	Member	2022-07-01		
			Non-Financial Personal Interest	Stonewall	Member	2022-07-01		
Henry Black	Chief Finance and Performance Officer	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee Primary Care Collaborative sub-committee	Indirect Interest	BHRUT	Wife is Assistant Director of Finance	2018-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Tower Hamlets GP Care Group	Daughter is Social Prescriber	2020-01-01		Declarations to be made at the beginning of meetings

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Dr Jagan John	Primary Care ICB Board representative	ICB Board Clinical Advisory Group ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee Primary Care Collaborative sub-committee	Financial Interest	Aurora Medcare (previously known as King Edward Medical Group)	GP Partner	2020-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Parkview Medical Centre	GP Partner	2020-05-01		Declarations to be made at the beginning of meetings
			Financial Interest	Together First Limited (GP Federation)	Practice is a shareholder	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Harley Fitzrovia Health Limited	Director and Shareholder	2018-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Diagnostics 4u (previously Monifieth Ltd)	Director and Shareholder	2020-10-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Aurora Medcare (previously known as King Edward Medical Group)	Other GPs are family members	2020-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	New West Primary Care Network	Brother / GP Partner is the Clinical Director	2020-11-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Personalised Care – Healthy London Partnerships and NHS England London Region	Clinical Lead	2017-05-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	North East London Foundation Trust – Barking and Dagenham Community Cardiology Service	GPWSI in Cardiology	2011-08-01		Declarations to be made at the beginning of meetings
			Financial Interest	Buxton Medica	GP partner is director and practice is share holder	2021-10-31		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barking & Dagenham, Havering and Redbridge University Hospitals Trust	Associate Medical Director for Primary Care in BHRUT	2022-09-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	UCL Global Business School for Health	Health Executive in Residence	2022-09-01		
Johanna Moss	Chief strategy and transformation officer	ICB Board ICB Population, Health & Integration Committee ICP Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee Primary Care Collaborative sub-committee Primary care contracts sub-committee						

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Marie Gabriel	ICB and ICP Chair	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICB Workforce & Remuneration Committee ICP Committee	Non-Financial Personal Interest	West Ham United Foundation Trust	Trustee	2020-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	East London Business Alliance	Trustee	2020-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Race and Health Observatory	Chair of the RHO	2020-07-23		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Member of the labour party	Member of the labour party	2020-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Confederation	Trustee Associated with my Chair role with the RHO	2020-07-23		Declarations to be made at the beginning of meetings
			Financial Interest	Local Government Association	Peer Reviewer	2021-12-16		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	UKHSA	Associate NED	2022-04-25		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Institute of Public Policy Research (IPPR)	Commissioner on the IPPR Health and Prosperity Commission	2022-03-13		Declarations to be made at the beginning of meetings
Marie Price	Director of Corporate Affairs	ICB Audit and Risk Committee ICB Board ICP Committee	Indirect Interest	Greater London Authority	Partner works as NE London region regeneration lead	2017-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Lower Clapton GP Practice, Hackney	Registered as a patient at a GP practice in NEL. Lower Clapton GP Practice, Hackney	2008-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Cadence Partners	Close friends with managing partner and head of operations. Cadence Partners is an executive search firm.	2018-12-03		Declarations to be made at the beginning of meetings
			Indirect Interest	Hackney Council	Close friend with Strategic Director Engagement, Culture and OD (also responsible for communications)	2020-01-01		Declarations to be made at the beginning of meetings

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Paul Calaminus	Chief Executive	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICB Board ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee	Non-Financial Professional Interest	East London NHS Foundation Trust	Chief Executive	2021-04-30		Declarations to be made at the beginning of meetings
			Indirect Interest	Department of Health	Partner is employed by Department of Health	2021-04-30		
Philip Glanville	Local authority rep on ICB Board	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICB Board ICB Finance, Performance & Investment Committee	Financial Interest	London Borough of Hackney	Mayor of Hackney	2016-09-19		
			Financial Interest	London Councils	Chair of Transport & Environment Committee	2020-10-01		
			Financial Interest	Local Government Association (LGA)	Member of LGA Environment, Economy, Housing & Transport Board	2018-08-01		
			Non-Financial Professional Interest	London Legacy Development Corporation (LLDC)	Non-Executive Director of London Legacy Development Corporation (LLDC) appointed by Hackney Council and the Mayor of London	2016-09-19		
			Non-Financial Professional Interest	London Office of Technology and Innovation	London Councils Digital Champion and lead for London Office of Technology and Innovation appointed by London Councils and the Mayor of London	2018-10-01		
			Non-Financial Professional Interest	Central London Forward	Board Member	2016-09-19		
			Non-Financial Professional Interest	Growth Borough Partnership	Board Member	2021-11-17		
			Non-Financial Professional Interest	Greater London Authority (GLA)	Co-Chair of Green New Deal Expert Advisory Panel	2021-03-01		
			Non-Financial Professional Interest	London Councils	Member of London Councils Ltd and London Councils Leaders' Committee	2016-09-19		
			Non-Financial Professional Interest	London Councils	Digital Champion / LOTI Lead	2020-10-01		
			Non-Financial Personal Interest	East London Foundation Trust	Resident Member	2019-08-01		
			Non-Financial Personal Interest	Unison	Union Member	2021-11-01		
			Non-Financial Personal Interest	Unite the Union	Member	2005-05-01		

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Zina Etheridge	Chief Executive Officer Designate of the Integrated Care Board for north east London	ICB Audit and Risk Committee ICB Board ICB Population, Health & Integration Committee ICB Workforce & Remuneration Committee ICP Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee	Indirect Interest	Royal Berkshire NHS Foundation Trust	Brother is employed as Head of Acute Medicine at Royal Berkshire hospital	2022-03-17		Declarations to be made at the beginning of meetings

- Nil Interests Declared as of 22/03/2023

Name	Position/Relationship with ICB	Committees	Declared Interest
Francesca Okosi	Chief People and Culture Officer	ICB Board ICB Workforce & Remuneration Committee ICS Executive Committee	Indicated No Conflicts To Declare.
Charlotte Pomery	Chief Participation and Place Officer	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Havering ICB Sub-committee Havering Partnership Board ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Maureen Worby	Local authority rep on ICB Board	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee	Indicated No Conflicts To Declare.
Caroline Rouse	Member of ICB Board (VCS rep)	ICB Board ICP Committee	Indicated No Conflicts To Declare.
Shane Degaris	ICB member	ICB Board ICS Executive Committee	Indicated No Conflicts To Declare.
Imelda Redmond	Non-Executive Member	ICB Audit and Risk Committee ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee	Indicated No Conflicts To Declare.
Manisha Modhvadia	Healthwatch	ICB Board ICP Committee	In progress

NHS
North East London
Integrated Care Board

Draft minutes – NHS North East London ICB board

25 January 2023 - 1.30pm – 4.00pm, May Suite, Waltham Forest Town Hall

Members:	
Marie Gabriel (MG)	Chair, NHS North East London and North East London Health and Care Partnership
Zina Etheridge (ZE)	Chief executive officer, NHS North East London
Paul Calaminus (PC)	NHS trust partner member
Shane DeGaris (SD)	NHS trust partner member
Cllr Maureen Worby (MW)	Local authority partner member – MS Teams
Mayor Philip Glanville (PGl)	Local authority partner member
Caroline Rouse (CR)	VCSE partner member
Diane Jones (DJ)	Chief nursing officer, NHS North East London
Henry Black (HB)	Chief finance and performance officer, NHS North East London
Paul Gilluley (PG)	Chief medical officer, NHS North East London
Dr Mark Rickets (MR)	Primary care partner member (from 2pm)
Diane Herbert (DH)	Non-executive member, NHS North East London
Imelda Redmond (IR)	Non-executive member, NHS North East London
Cha Patel (CPa)	Non-executive member, NHS North East London
Sue Evans (SE)	Interim non-executive member and Audit Chair, NHS North East London
Attendees:	
Manisha Modhvadia (MM)	Healthwatch participant
Will Tuckley (WT)	Local authority executive participant
Charlotte Pomery (CP)	Chief participation and place officer, NHS North East London
Francesca Okosi (CO)	Chief people and culture officer, NHS North East London
Johanna Moss (JM)	Chief strategy and transformation officer, NHS North East London
Marie Price (MP)	Director of corporate affairs, NHS North East London
Anne-Marie Keliris (AMK)	Head of governance, NHS North East London
Anna McDonald (AMc)	Senior governance manager, NHS North East London
Sam Walker (SW)	Engagement and community communications manager, NHS North East London (item 2.0)
Matthew Knell (MK)	Senior governance manager, NHS North East London
Apologies:	
Dr Jagan John (JJ)	Primary care partner member

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting including members of the public who had joined the board meeting to observe either in person or via the MS Teams virtual link. The Chair advised people of the fire alarm procedure and other housekeeping matters before proceeding.

1.1	**Declaration of conflicts of interest**
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the ICB. No additional conflicts were declared. Declarations declared by members of the ICB are listed on the ICB's Register of Interests. The Register is available either via the Governance Team or on the ICB's website.
1.2	**Minutes of the last meeting**
	The minutes of the meeting held on 30 November 2022 were agreed as a correct record.
1.3	**Action log**
	The ICB board noted the action taken since the last meeting. The Chair referred to the action relating to quality and 'non-constitutional' performance and asked IR, as Chair of the Quality, Safety and Improvement Committee to share a first draft of what the format for a future quality report to the board should be to ensure the content meets the requirements of the board. **ACTION: IR/DJ.**
2.0	**Resident story**
	The Chair welcomed Sam Walker (SW) to the meeting who shared the story on behalf of a local resident who had been unable to attend the meeting herself but was happy for her concerns to be shared alongside some positive feedback about her experiences overall using a number of services across primary and secondary care including her local GP practice, phlebotomy services (blood testing) and Newham University Hospital. SW gave an overview of the resident's background; she has lived in north east London for over 60 years; lives alone since losing her husband six years ago; she has limited mobility, exacerbated by shielding during the pandemic; has a number of long-term conditions which she manages, including Addison's disease, osteoporosis and type 2 diabetes and through her husband, she also has experience of cardiology and Alzheimer's care. The key concerns were: • The resident's regular GP appointments, since the pandemic, have been mainly telephone consultations and she is concerned that any broader assessment of her health and wellbeing cannot be carried out without being seen in person. • The level of information the resident is asked to provide by reception staff and the concern that they do not have a clinical background and often live locally. She understands it is the role of reception staff to ease the burden on doctors but finds extensive questioning to be a clear barrier to her care. • Having to share her medical history when speaking with a new doctor each time to ensure a continuity of care. • Access to some sessions are dependent on her being taken by her daughter in her car or taking a taxi due to limited mobility.

	Discussion points included: • How the resident story demonstrates that residents would like to have services closer to home. • The need to consider other sites where services could be delivered in order to improve access for our residents. • The need to communicate some of the positive feedback that Healthwatch has received in regard to the benefits to some residents of having digital appointments rather than face to face. • The importance of strengthening communication and engagement with residents so they have a clearer understanding of the various options available to them in order to access treatment. • How we can work with the voluntary sector to enable residents to have easy access services. • The need to communicate and explain the wider role of receptionists in regard to triage and the importance of ensuring that reception staff feel supported. • The need to improve ways of working so that patients do not have to repeat medical history multiple times. The Chair thanked the resident for sharing their experiences via SW. Progress on the resident stories will be followed up. **ACTION: CP**
3.0	**Chair and chief executive reports**
	3.1 Chair's report The Chair presented her report which provided an update on the most significant activities undertaken by the Chair and non-executives since the last ICB board meeting. The following key areas were highlighted: • The Chair welcomed Cha Patel (CPa) to her first board meeting as a non-executive member and the Chair advised that from 1 February 2023, Cha would also be taking on the role of Audit Chair. The Chair expressed her thanks to Sue Evans for covering both roles in the interim period. • Interim Integrated Care Strategy - the Chair advised that board members would be asked later in the meeting to adopt the interim Integrated Care Strategy and gave a summary of the key discussion points from the Integrated Care Partnership meeting held on 11 January 2023. o the interim strategy will be taken back to 'places' and Health and Wellbeing boards in order to consider the additional actions that need to be undertaken locally which will help to deliver the strategy. o Partners recognised that prevention takes place in different ways and at different levels. o The importance of the wider context of social care and local government was emphasised together with the particular role of the voluntary and community sector as equal partners. The ICB board noted the report. **3.2 Chief executive's report** ZE presented her report and highlighted the following key areas: • System resilience – this has been the focus during December and January and local health and care services have been under enormous pressure for a range of reasons such as Covid-19, flu and industrial action. Despite the pressures, our workforce has continued to support residents and thanks were expressed to the workforce as a whole.

	• A recent visit to King George's Hospital – ZE gave an overview of some of the innovative work being undertaken across the system including robotic surgery. • Emergency Preparedness, Resilience and Response (EPRR) – board members were asked to receive the 2022 statement of compliance as part of the EPRR assurance process. Discussion points included: • CQC reports on the four Urgent Treatment Centres (UTC) operated by the Partnership of East London Co-operatives (PELC) in Barking and Dagenham, Havering and Redbridge – ZE advised that we are working closely with PELC to ensure that the improvements required are met. A robust focus on the quality of the whole urgent and emergency care pathway in outer north east London is needed. We need to be able to demonstrate that our residents' experience has improved. Concerns were expressed that the current situation is unacceptable for our residents and that assurances that the four UTCs are fit for purpose will need to be given. ZE clarified that progress will be reported back through the ICB's Quality, Safety and Improvement Committee. No financial implications on the ICB are anticipated at this stage. • The level of preparedness and partnership working across the system including the London Ambulance service, clinicians and others to support residents during the industrial action. • ZE gave an overview of the London-wide work being undertaken independently across London looking at the urgent care system and how lessons learnt from that could be replicated in north east London as we move forward. • The lessons learnt in regard to how messages about Covid-19 and flu vaccinations are communicated and received by the public. DJ summarised some of lessons learnt in north east London and the feedback we have shared with the national team. The work being undertaken in Hackney by Healthwatch looking at different ways of working was referenced. The ICB board: • Noted the report. • Received the Emergency, Preparedness, Resilience and Response statement of compliance – 2022 as part of the EPRR assurance process. The Chair asked HB to feedback on how our EPRR compliance rating compares to ratings given to other ICBs. **ACTION: HB.**
4.0	**Strategy**
	4.1 Interim Integrated Care Strategy JM presented the interim Integrated Care Strategy and highlighted the following key points: • A final draft of the interim strategy was presented to the Integrated Care Partnership (ICP) at its meeting on 11 January 2023. • JM expressed her thanks on behalf of the ICB board to system partners, including place based-partnerships and health and wellbeing boards, residents and patients for their active engagement in creating and shaping the new strategy. • As part of the engagement, six cross-cutting themes have been identified which are key to developing innovative and sustainable services with a greater focus upstream on population health and tackling inequalities.

- The interim strategy sets a clear direction for current planning including the new NHS Joint Forward Plan which is due to be submitted to NHS England before the end of March 2023.
- Final minor amendments will be made to the interim strategy before it is published on the ICB's website and it will then be tested further with local people at a 'Big Conversation' activities being planned for the Spring. It will be reviewed again following the publication of further guidance which is expected in June 2023.
- Further work will also be undertaken to develop the success measures from a resident's perspective in terms of their experience and outcomes.

Key discussion points included:

- The views given as part of the discussion at the recent ICP meeting in January 2023 and JM assured the board that the views will be included as part of the amendments that will be made before the interim strategy is published.
- The need for Place to be involved in the delivery of the strategy.
- The need to ensure the strategy is aligned with the work being undertaken at a local level.
- The need to have more emphasis on planning infrastructure and population growth particularly in relation to the borough of Newham.
- The need for a collective approach to ensure the balance is right between the strategy and the Joint Forward Plan.
- The need for our partnership and our residents to be clear on what our priorities are and what the time frames are for delivery.
- The need for the strategy to reflect the health inequalities that exist within some services in north east London.
- How voluntary and community groups will use the strategy to inform what they do and where the gaps are. Residents will want to know what difference the strategy will make to them.
- The need for the strategy to reference other strategies particularly the Estates Strategy and Older People Strategy. JM explained there is a requirement to produce an ICB Estates Strategy which will be presented to the ICB board in draft format at a future meeting. **ACTION: JM.**
- The importance of recognising the need to allow space for dealing with current issues as well as focusing on the future.

JM to take the discussion points forward. **ACTION JM.**

The ICB board:

- Adopted the interim Integrated Care Strategy, noting that minor amendments will be made that take in to account the discussion at the ICP meeting on 11 January and the ICB board discussion.

4.2 Joint Forward Plan update

JM presented the Joint Forward Plan and highlighted the following key points:

- ICBs together with their NHS trust and foundation trust partners are required to produce a Joint Forward Plan (JFP).
- We are proposing to have a much broader approach by adopting the JFP as a delivery mechanism for our Integrated Care Strategy.
- Close engagement with system partners is essential and we will work together with local authorities, place-based partnerships and voluntary sector colleagues to ensure we have a collective and jointly owned detailed

	plan which we will develop as we mature as a partnership to ensure the JFP is not viewed as an NHS plan. Key discussion points included: • The importance of knowing how we will take this forward in terms of functions and responsibilities and what it means for our workforce, noting that they are not all residents within north east London. • The need to fully engage with local authorities as to what is needed and when including what is needed in terms of governance at a local level. • The need to build on existing plans that system partners already have to make sure they are aligned. • The need to include housing and the wider environment. JM confirmed that the plan is to present a first draft at various meetings for comments before presenting the final draft at the ICB board meeting on 29 March 2023. **ACTION: JM.** The ICB board noted the updated on the Joint Forward Plan. **4.3 Deep dive into primary care** JM began by introducing Sarah See as the recently appointed Managing Director of Primary Care. The report highlighted: • The challenges facing general practice in north east London • Opportunities within primary care. • The Fuller Review - which has created a new vision and case for change for integrated primary care and how we are implementing the recommendations in north east London. The Chair welcomed the deep dive as a first step but noted that the focus was on general practice and asked for a further wider primary care deep dive for a future meeting based on quality and how we can improve variation from a patient perspective working with Healthwatch and the voluntary sector. **ACTION: DJ/PG.** Key discussion points included: • How primary care is one of the key areas of focus for levelling up across north east London. • The need for the follow-up wider primary care deep dive to detail what we aim to achieve for our residents and what the minimum is that we expect. • We need to ask our residents what they want primary care services to provide. • The risks relating to the ICB hosting the dental, optometry and community pharmacy contracts – board members were assured that discussions on this are taking place at the Finance, Performance and Investment Committee. The ICB board noted the deep dive report.
5.0	**Board assurance**
	5.1 Board Assurance Framework CP presented the updated Board Assurance Framework (BAF) following the feedback received at the last board meeting held on 30 November 2022. Current key risks on the BAF relate to: • Collaborative working across partners • Wider determinants of health/environment

	• Quality and safety of care • Delivery against control total and operating plan • Workforce • Population growth The corporate risk register will continue to be reviewed and the Head of Governance will be meeting with the risk champions to review risks and current mitigations. The ICB and ICS executive team will continue to discuss organisation and system wide risks to ensure further development and refinement of the BAF. The Chair welcomed the progress made since the last version and advised that she will meet with Cha Patel, members of the Governance Team and other relevant executive colleagues before the next board meeting to discuss how the BAF could be developed even further. **ACTION: Chair/CPa/CP** The ICB board: • Noted the updated Board Assurance Framework.
6.0	**Finance and performance overview**
	HB presented the report and provided an update on recent discussion with NHS England about submitting a revised forecast outturn for month 10. The report also provided an update on proposed changes to the Scheme of Reservation and Delegation (SORD) which board members were asked to approve. The key highlights of the finance and performance overview were: • The overall financial position remains extremely challenged. • Discussions are being held with NHS England and we are going to be submitting a revised forecast outturn for month 10. • We have agreed a revised deficit plan of approximately £35m which is recognised by NHS England. • Committing to an agreed revised plan means we will receive a small additional allocation and we also qualify for some additional capital monies for the next financial year. • A new dashboard is being piloted based on comments on suggestions from board members at previous board meetings. Key discussion points on the finance section of the report included: • The improvements made in regard to reductions in agency costs and non-permanent staff expenditure. • The small improvements in productivity being seen since coming out of the pandemic. • The reasons for the proposed changes to the Scheme of Reservation and Delegation (SORD). • How the capital pipeline is prioritised and the plan to develop the pipeline with clinical indicators going forward. Key discussion points on the performance section of the report included: • The difficulties in having demographic breakdowns in the performance report. Mental health performance was given as an example and a suggestion was made for the need to have a focus on one item each time in order to explore equity and in-equality equality. • It was noted that the performance report is still acute focussed and that a broader level of performance data is needed at Place level.

	• It was suggested that discharge data and ambulance data would be useful. • The need to stop using RAG ratings. • How we rate performance against the trajectories that we set ourselves. • How having trajectory over time would be helpful. • How this translates to Place and neighbourhood level. The Chair suggested the need for further discussion outside of the meeting on what would need to be included in a quality report to the board going forward and the constitutional standards information that needs to be included in the performance report in order to achieve the right balance. **ACTION: HB/DJ –** *Note – this action is linked to the action for IR/DJ under 1.3.* The ICB board: • Noted the content of the report and the key risks to the expected year-end breakeven position. • Approved the proposed update to the financial scheme of reservation and delegation within the Standing Financial Instructions (SFIs). • Noted the content of the performance update and note the key risks of delivery.
7.0	**Governance**
	7.1 Executive committee exception report ZE presented the report and noted that the key points had mostly been picked up as part of the board discussion. The ICB board noted the exception report. **7.2 Audit and Risk Committee exception report** SE presented the exception report. The key points were: • In addition to 'business as usual' matters, the committee is looking at what system collaboration means in audit terms. • The committee noted the work undertaken by the Emergency Preparedness, Resilience and Response lead noting that the ICB is a category one responder. • Committee members were given an overview of the recently commissioned Freedom to Speak Up 'Guardian Service' for staff. • The Committee received updates on recent audits undertaken by the Internal Auditor together with an update on the work of the Local Counter Fraud Specialist team. The Chair referenced the report on the new 'Freedom to Speak Up' guardian service for staff and asked whether there is a need for the board to be sighted on the staff voice. DH and DJ gave an overview of the discussions being held about the processes that our system partners have in place for speaking up and the Chair said she would welcome a report on that at a future board meeting. **Action: DJ/DH.** The ICB board noted the exception report. 7**.3 Workforce and Remuneration Committee exception report** DH presented the exception report. The key points were: • The Committee held a detailed discussion on the continued development of the ICS People and Workforce Strategy and fed back on how the committee

	welcomed the level of engagement taking place with all sectors across the system including local authorities, voluntary sector and primary care as well as our existing workforce. • The committee received a quarterly report presented by the ICB's Freedom to Speak Up Guardian executive lead and an overview of the recently commissioned Freedom to Speak Up 'Guardian Service' was given. Committee members welcomed having a more independent approach for staff. • An update on the internal ICB re-structure was received. The ICB board noted the exception report. **7.4 Quality, safety and improvement (QS&I) committee exception report** IR presented the exception report and assured the board that future agendas for this committee will focus on the key concerns and challenges that the system is facing such as A&E and the interactions with mental health. The ICB board noted the exception report. **7.5 Finance, performance and investment committee exception report** HB presented the exception report. The key highlights were: • The Committee received an update on the current finance and performance position and discussed the measures being taken and the risks that need to be mitigated to meet the year-end financial position requirements set by NHS England (NHSE). • The Committee endorsed the draft north east London Financial Strategy and welcomed the commitment to place based working, noting the importance of transparency across the system. • The Committee approved a business case for a community phlebotomy service that will operate across Barking, Havering and Redbridge delivered by North East London NHS Foundation Trust (NELFT). The ICB board noted the exception report. **7.6 Population health and integration committee exception report** The Chair presented the exception report and highlighted the following: • The Committee considered whether there is a need to combined strategies that have similar content and it was agreed that further discussion about that will be held outside of the Committee meeting. • The Committee discussed the importance of the relationship between place and collaboratives and have asked that representatives from each attend the meeting going forward which will add to the integration of the Committee. • A paper on the big' conversation will be presented at the next meeting to further shape how we are going to work with our local communities. The ICB board noted the exception report.
8.0	**Board forward plan**
	The Chair recapped on discussions held earlier in the meeting and suggested the following need to be added to the forward plan: • Regular deep dives

	• A further deep dive on the wider primary care - focussed on quality and how we can improve variation in services from a patient perspective working with Healthwatch and other voluntary sector colleagues. **ACTION: DJ/PG.** • Quality report. **Action: DJ/IR** The Chair also suggested it would be useful to include board development session agenda items on the forward plan for information going forward. **ACTION: CP**
9.0	**Questions from the public**
	The Chair welcomed the questions that had been submitted by members of the public in advance of the board meeting and added that although there would not be enough time to go through all the questions in the meeting, four of them would be addressed and the remaining responses would be provided outside of the meeting. Mary Burnett asked a number of questions in advance of the meeting. A response to the question below was provided in the meeting and responses to the remaining questions would be given outside of the meeting: **Q:** Which specific health inequalities does the ICB consider key for NE London? **A**: Within the interim Integrated Care Partnership (ICP) strategy, based on data and insight and engagement, we have identified two priority dimensions for tackling health inequalities across north east London and three priority underserved groups in north east London: Two priority dimensions; Poverty – a quarter of our residents live in one of the most deprived 20% areas of England and more than 1 in 5 children in some boroughs live in poverty, with rates rising in nearly all places; Ethnicity – more than half of our population in NEL are from a minority ethnic background. The pandemic highlighted and widened inequalities between ethnic groups. Three priority groups; people with learning disabilities and autistic people; people experiencing homelessness; carers JM added that whilst these are included in the interim ICP strategy, we will continue to consult on these and welcome feedback as we develop the full strategy over the coming months. PGI questioned how the decision on the priorities was reached. and JM agreed to provide an update explaining that they are first draft proposals at this stage. **ACTION: JM.** The Chair commented that the question had prompted the board to ask further questions which demonstrates the importance of receiving questions from members of the public. Jan Savage asked a number of questions in advance of the meeting. A response to the question below was provided in the meeting and responses to the remaining questions would be given outside of the meeting: **Q:** What action is NEL Health and Care Partnership (HCP) taking to ensure that patient data security is in line with the recommendations made by the National Data Guardian and Chair of the UK Caldicott Guardian Council? **A:** NHS organisations are mandated to evidence a set of data processing requirements annually as described in the NHS Data Security and Protection Toolkit (DSPT).

	Sybil Ritten asked a number of questions in advance of the meeting. A response to the question below was provided in the meeting and responses to the remaining questions would be given outside of the meeting: **Q:** Knee and hip surgery pathway - Is this an official or unintended pathway.? Is this a decision made by a clinician, an administrator or an algorithm? **A:** The ICB commissions a wide range of treatment and diagnostic services from NHS providers as well as independent sector providers. When clinicians are seeing patients, they should be able to discuss a choice of options with patients based on their condition and available provider. Many NHS providers continue to deal with the backlog caused by the pandemic and consequently have long waits for appointments. There are a number of independent sector providers offering surgery in north east London, generally to people who are less complex in terms of procedures or other underlying health conditions. Patrick Morgan was present in the meeting and asked his question directly to the board: **Q:** How does the ICB intend to include the patient voice, particularly PPGs, at its meetings and decision making? **A:** Since the ICB was set up in July 2022 we have been working on establishing our new governance arrangements at a north east London level and through our seven place-based partnerships and sub-committees. We are aiming to be much more integrated as a system between health and care with Healthwatch and the voluntary and community sector very much embedded at a north east London level and within places. We recognise the important role to PPGs play in improving local practice arrangements within local neighbourhoods and primary care networks (PCNs) and we would like to draw on your expertise and experience. As part of the discussion MM introduced herself as the Healthwatch participant at the board meetings and said she would liaise with the Healthwatch organisation covering Mr Morgan's area. MR clarified that Healthwatch represent the patient voice on the primary care collaborative and that discussions as to whether that is sufficient are being held. A summary of questions submitted and answered by the board will be uploaded here https://northeastlondon.icb.nhs.uk/about-the-north-east-london/our-board/questions-from-members-of-the-public/
10.0	**Any other business and close**
	There were no further items for discussion.
	Date of next meeting – 29 March 2023

North East London
Integrated Care Board

ICB board – action log

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
7.0 Finance and performance overview	**28 Sept 2022**	Discussions about considering 'non' constitutional performance together with quality to take place outside of the board meeting.	DJ/ HB	April 23	The aim is to have a joint report from April 2023.
1.3 Action log	**25 Jan 2023**	Chair of the Quality, Safety and Improvement Committee to share a first draft of what the format for a future quality report should be with the board chair to ensure the content meets the requirements of the board.	IR/ DJ	To be confirmed with Chair	Draft report being developed.
1.3 Matters arising	**30 Nov 2022**	Progress on resident stories to be followed up.	CP	March 23	Complete.
3.1 Chair's report	**30 Nov 2022**	Clinical leadership to be added to the agenda for discussion at a future meeting.	PG	March 23	Complete. Added to board forward plan for May 2023.
3.2 Chief executive's report	**25 Jan 2023**	The Chair asked for feedback on how our Emergency Preparedness, Resilience and Response (EPRR) compliance rating compares to ratings given to other ICBs.	HB	March 23	A briefing will be circulated to members.
4.1 Interim Integrated Care Strategy	**25 Jan 2023**	JM to take the discussion points forward. A draft ICB Estates Strategy to be presented to the board at a future meeting.	JM JM	March 23 July 2023	Complete. Agenda item scheduled for March 2023.

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
4.2 Joint Forward Plan	**25 Jan 2023**	Final draft Joint Forward Plan to be presented to the board at the next meeting.	JM	March 23	Complete. Agenda item scheduled for March 2023.
4.3 Deep dive into primary care	**25 Jan 2023**	A further wider primary care deep dive was requested for a future meeting based on quality and how we can improve variation from a patient perspective working with Healthwatch and the voluntary sector.	DJ/ PG	July 23	Agenda item scheduled for July 2023.
5.1 Board assurance framework	**25 Jan 2023**	A meeting to be arranged involving the ICB Chair, Cha Patel, members of the Governance Team and other relevant executive colleagues before the next board meeting to discuss how the BAF could be developed even further.	CP	March 2023	Complete. Meeting held on 28 February 2023.
6.0 Finance and performance overview	**25 Jan 2023**	Further discussion to take place outside of the meeting on what would need to be included in a quality report to the board going forward and the constitutional standards information that needs to be included in the performance report in order to achieve the right balance.	HB/ DJ	TBA	Linked to action 1.3.
7.2 Audit and risk committee exception report	**25 Jan 2023**	A report to be presented at a future board meeting on the processes that our system partners have in place for 'speaking up'	DH/ DJ	May 2023	Agenda item scheduled for May 2023 meeting.
8.0 Board forward plan	**25 Jan 2023**	The following to be added to the board forward plan: • Regular deep dives • A further deep dive on the wider primary care - focussed on quality and how we can improve variation in services from a patient perspective working with Healthwatch and other voluntary sector colleagues. • Quality report. • Board development session agenda items for information going forward.	CP	March 23	Complete. Items scheduled on board forward plan

CLOSED ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
1.4 Action log	**30 Nov 2022**	Updated governance principles to be included in the board papers going forward along with our purpose and design principles.	CP	Jan 23	Complete.
4.1 Board assurance framework	**30 Nov 2022**	Discussion points to be considered as part of the on-going development of the BAF.	CP	Jan 2023	Complete.
5.1 Integrated care strategy	**30 Nov 2022**	Discussion points to be taken forward as part of the development of the Integrated Care strategy.	JM	Jan 2023	Complete - discussions points have been shared and are being taken forward as part of the development of the Integrated Care Strategy.
5.2 Integrated Care System workforce strategy	**30 Nov 2022**	Discussions points to be taken forward as part of the on-going development of the Integrated Care System Workforce Strategy.	FO	March 2023	Complete - discussions points have been shared and are being taken forward as part of the on-going development of the Integrated Care System Workforce Strategy.
6.0 Finance and performance overview	**30 Nov 2022**	Discussion points in regard to future finance and performance reports to be taken in to account and consideration to be given as to what needs to be reported at Place level and what needs to be reported at board level by way of an exception report.	HB	Jan 2023	Complete - revised format for the report being piloted and included in the January board papers following a review at the Finance, Performance & Investment Committee on 6 January 2023.
8.0 Board forward plan	**30 Nov 2022**	Discussions to be held at the local authority chief executives meeting, voluntary sector collaborative and Healthwatch collaborative about items they would like included on the forward plan.	CP/ MP	Jan 2023	Complete - nothing further to add to forward plan following the recent conversations but will be regularly followed up.

North East London
Integrated Care Board

NHS North East London ICB board

29 March 2023

Title of report	Chair's Report
Author	Marie Gabriel
Presented by	Marie Gabriel - Chair
Contact for further information	Marie Gabriel, Chair Marie.gabriel1@nhs.net
Executive summary	• Key issues: This paper is focused on outcomes from meetings of the North East London Integrated Care Partnership Steering Group and the North East London Trust Chairs and ICB Non Executive community. The Board is asked to consider these outcomes to inform our conversations about the Joint Forward Plan and Financial Strategy, which are on our agenda today. • Recommendation: To receive and note the report, in particular the appointment of Councillor Neil Wilson as Deputy Chair of the NEL ICP Steering Group.
Action required	For noting
Previous reporting	NEL Chairs Meeting
Next steps/ onward reporting	ICP Steering Group and Non-Executive views taken into account by this Board meeting
Conflicts of interest	None
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health (Joint Forward Plan will enable us to focus our efforts on improving population health and our work on anti- racism will enable us to focus on communities most affected) • To tackle inequalities in outcomes, experience and access (through the Joint Forward Plan strategic priorities and our anti-racism work) • To enhance productivity and value for money (through the approach identified within the Financial strategy and our anti racism work) • To support broader social and economic development (through the Joint Forward Plan strategic priorities, financial decisions and focus on inequity).
Impact on local people, health inequalities and sustainability	The contributions of partners to our discussions on the Joint Forward Plan will enable the ICS to maximise the impact of our joint work on improving outcomes, tackling health inequalities and ensuring sustainability.

Impact on finance, performance and quality	The contribution of partners to our discussions on the Financial Strategy particularly steer us towards a focus on productivity and enabling a transformation in outcomes.
Risks	The content of the report will inform strategic risk mitigations, including informing how we approach prioritisation.

1.0 Introduction

1.1 I want to begin this report by acknowledging the continued dedication and contribution of our Integrated Care Board staff and recognising the challenging time that they are experiencing given recent national announcements about reductions to the ICB running costs budget. I have attended the last two Integrated Care Board staff briefings and have been impressed with the response, staff have been understandably concerned but have also begun to help us think through choices. The senior team and I know that this Board are committed to be being transparent, inclusive and supportive as we develop our response.

1.2 The report informs the Board of the key points arising from North East London Integrated Care Partnership Steering Group and North East London Non-Executive meetings, to ensure their views are taken into account in Board decision making. It also updates the Board on a London ICB commitment to anti-racism

2.0 Integrated Care Partnership

2.1 At its March meeting, the Integrated Care Partnership Steering Group considered a working draft of the Joint Forward Plan and made the following comments.

- That workforce and diversity, along with the system and international mobility of our communities should both be added to the uniqueness of our system.
- That we should consider the connecting places that exist for our communities, places where social isolation and loneliness are addressed by charities, faith groups and small informal groups, places where important things happen, where trust is built and individual progress made.
- The importance of our relationship with higher education institutions was also highlighted both in terms of innovation and future workforce plans.
- The term ‘transformation’ was considered and whether this was a term that fully captured the ongoing journey of improvement that we were on.
- It was noted that we are constantly transforming and changing, so we must ensure that we both communicate these changes effectively with our communities and very importantly we engage our community in defining that change.
- The need to ensure we are clear on what measures we are using for population, resident population or GP registered population.
- That a shorter, more accessible version would be produced of the Joint Forward plan and the Interim Integrated Care Strategy would be produced once both were completed and agreed.

2.2 The ICP steering group also considered governance, and agreed that Councillor Neil Wilson should be the Deputy Chair of the group and to make recommendations to the Integrated Care Partnership, that it also considers appointing a deputy. The meeting also considered the agenda for the next Integrated Care Partnership and agreed the

public meeting should be followed by a deep dive workshop focused on co-production. It was agreed that this workshop should showcase best practice, identifying the challenges and also support building a joint understanding of what co-production, as a living definition, means for us all as a whole system. This discussion helped to inform our consideration of the Integrated Care Partnership's forward plan of agenda items. It was agreed that agendas should ensure a discussion on the progress of the 4 flagship priorities in the public part of the meeting, followed by a deep dive into one of our cross-cutting themes, as these themes defined how we would work together as a partnership. Finally, it was agreed that our July meeting would be in person, to further build relationships.

3.0 Chair and Non-Executive Activities

3.1 The February NEL Trust Chairs and ICB Non-Executive members' meeting once again considered the developing Joint Forward Plan. The meeting concluded that, whilst they understood that the five-year plan would be refreshed every year; there was a need to have a clear approach to this first plan as a foundation for us to build upon in future years. This approach required us to be explicit and specific about the key choices we were making as an ICS. Other comments included the need to recognise our opportunities as well as the challenges, to emphasise population growth, to seize the opportunity to innovate and for individual partners' strategies to align on ambition.

3.2 The meeting also discussed the financial strategy, which is an item on our agenda today. Comments included the need to identify key priorities to allocate funding, aligned to our priorities and the to reduce total costs across organisations as part of our productivity work. The meeting also highlighted the need to ensure that we invest in transformation for longer term benefit and consider the narrative around mental health and the place of virtual wards. Following an early discussion on recruiting and retaining workforce, the meeting queried whether we have the resources to consider levelling up on Inner/Outer London Weighting or is this something we should join together across London to advocate.

3.3 The Board are aware that I sit as one of the two ICS representatives on the Mayor of London's Health Board and that as part of that membership I am the Mayor's Champion for Tackling Structural Racism. In that role, I recently met with London's ICB Chairs and Chief Executives and secured their unanimous agreement to making a public anti-racist commitment. The Chairs and Chief Executives were clear that this needed to be a commitment with clear actions, with the content developed by each ICB to ensure relevance and meaning. In North East London, we are convening a working group, chaired by myself, to support the development of our own commitment and action plan and will be supported by our interim EDI Director, Pav Akhtar, who will co-ordinate engagement with partners.

4.0 Recommendation

4.1 The Board is asked to receive and note the report, in particular the appointment of Councillor Neil Wilson as Deputy Chair of the NEL ICP Steering Group.

Marie Gabriel – Chair
21/03/2023

North East London
Integrated Care Board

NHS North East London ICB board

29 March 2023

Title of report	Chief Executive Officer's Report
Author	Zina Etheridge, Chief Executive Officer
Presented by	Zina Etheridge, Chief Executive Officer
Contact for further information	Laura Anstey l.anstey@nhs.net
Executive summary	The following report provides an update on our continued development of NHS North East London.
Action required	Note and agree the proposed corporate objectives for the board for 2023-24.
Previous reporting	N/A
Next steps/ onward reporting	N/A
Conflicts of interest	N/A
Strategic fit	The report relates to the chief executive's intentions for the ICB and ICS and aligns to our strategic purpose, priorities and objectives: • 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 ICB will enable us to have greater impact as we are enabled to work in a more integrated way across health and care organisations in north east London.
Impact on finance, performance and quality	N/A
Risks	N/A

1.0 Introduction

1.1 Since the January meeting the focus has continued to be on system resilience, managing pressures on urgent and emergency care and continuing to manage the impact of industrial action. In addition, work has been underway to deliver our operating plan for 2023-24 with an initial submission shared with NHS England (NHSE) at the end of February ahead of the final submission in March. Work also continues on our joint forward plan which will be the delivery plan for the Integrated Care Partnership Strategy. The ICB continues to develop its role as a system convenor, bringing partners together across North East London to share good practice and work together. The following paper highlights some of the key areas of focus since January and includes an appendix on our proposed corporate objectives for 2023-24.

1.2 This paper is for information with agreement sought for the corporate objectives.

2.0 System resilience

2.1 Through February and March continued focus has been on managing pressures across urgent and emergency care, primary care, social care and the wider system. To manage these pressures, the North East London system comes together on variety of levels, including the daily emergency care hub meeting which assesses the level of risk on each site and manages mutual aid. We now need to use the learning from this winter to build a system resilience plan to take us through next winter and other pressures. NHSE has recently published an urgent and emergency care recovery plan and we are working through how to address these requirements.

2.2 **Industrial action.** A co-ordinated system of national, London-wide and local incident management teams has been established to manage the series of days of industrial action. In North East London this is led by the Chief People and Culture Officer. North east London has been impacted significantly by industrial action by Unison (ambulance services) and the BMA (junior doctors). Concerted action has been taken across the system to minimise the impacts on patient safety of all days of industrial action, including through providing clinicians to support the triage of 999 calls, support from social care colleagues in maximising discharge in the run up to strikes, and switching a significant proportion of primary care appointments to urgent/on the day booking during the junior doctors strike. Working with the London Ambulance Service (LAS) we have sought to understand and learn from the ambulance staff strike but assessing quantitative impact is difficult.

There have been four days of action in the ambulance service, and the local system coped well with the constraints. The 72-hour strike action by the junior doctors led to the rescheduling of around 600 planned care procedures and 8000 outpatient appointments. This was required to release consultant staff to focus on urgent and emergency care patients. The North East London system was not directly affected by the nurses industrial action called by the Royal College of Nursing (RCN). On behalf of the board I would like to express our gratitude for all of those who worked really hard to support and care for local people during the industrial action.

A pay deal has now been proposed which has been welcomed by many unions. However this deal does not apply to doctors as they are on a different set of terms and conditions. It is currently unclear how a significant portion of the pay deal for next year will be funded.

3.0 Running cost allowance

3.1 At the beginning of March NHSE wrote to all ICBs to inform them of reductions to ICB running cost allowances. All ICBs running costs allowances will remain the same in 2023/24 as 2022/23, necessitating a small reduction in costs to take account of inflation. More significantly there is a requirement to reduce running costs by 30% 2025/26 (with at least 20% to be delivered in 2024/25). Neither of these reductions allow for inflation. In the meantime, we have been preparing for a staff consultation over recent months to reconfigure the ICB to deliver its new and expanded role and we have been modelling a number of different budget scenarios. Staff are aware of the recent information and we are working through the detail of what this means ahead of a formal consultation. We are also working with partners about the options and implications of these savings. A number of support mechanisms have been put in place for staff to ensure they have the support the need during this time.

4.0 Staff survey

The latest staff survey results have been published nationally this month. These present a snapshot view of the organisation during October and November and some further work is ongoing to analyse the key themes and findings in more detail so that we can quickly agree an action plan. There are a significant number of areas for improvement. The initial focus will be on the following key themes: ensuring the process for the restructure is fair, clear and transparent, tackling inequitable experiences based on people's protected characteristics and addressing experiences of bullying and harassment. An item will be taken to the workforce and remuneration committee on the survey results.

6.0 Convening our partners

6.1 **North East London safeguarding chairs**. In February I convened a meeting with adults and children's safeguarding chairs across North East London. This was an opportunity to update them on the work and focus of the ICB and then discuss some of the key topics and priorities in safeguarding and areas for further focus such as accountability, research and innovation, escalation pathways and the ICB as a learning system. It was a really helpful session and chairs agreed that they would like to come together like this on a regular basis.

6.2 **North East London MP meeting**. As part of our ongoing stakeholder engagement process we convened a meeting with all our local MPs to brief them on the topics of urgent and emergency care and mental health. These meetings will take place regularly and provide an opportunity to share the work of the ICB, hear directly from elected representatives about the issues that matter most to their constituents and demonstrate the value in working as a system on particular issues for the benefit of the wider population.

6.3 **Roundtable on workforce with Health Education England**. In February we welcomed the chair of Health Education England, Sir David Behan, to a roundtable on workforce and how the ICB is working across the system to meet our priority on workforce and employment. This was an opportunity to showcase some fantastic work on apprenticeships, primary care, building and accessing careers, learning from our work on resourcing mass vaccination sites across North East London and how we are approaching integrated planning as well as work underway to develop our system wide workforce strategy. It was fantastic to hear about work to date and lots of enthusiasm and commitment in the room. There is lots more to do but some great foundations to build on as we continue to develop the overall strategy and approach.

6.4 **Showcasing our work to NHS England.** In March I hosted a visit with NHS England to showcase our system. We spent some time discussing population growth and the impact this will have over the next 10-20 years and how we are already working with partners to manage what this means for health and care services. We also facilitated a round table with voluntary and community organisations sharing the approaches, assets and stories around co-production and engagement. This demonstrated the breadth of activity in north east London, as well as the expertise and good practice underway. We also held a second round table on system resilience bringing together a range of partners covering topics such as the warm places work in Havering and the importance of being able to share data to really target our help through to urgent and emergency care, the work of integrated discharge hubs and urgent community response. There was enormous value in the interaction between the different parts

of the system, and understanding how the different parts of our system support overall and individual resilience is an important task for us.

7.0 System visits

7.1 **Health Spot** – I visited Health Spot at the Spotlight youth project in Poplar in February. The work being done is both really inspiring and a brilliant example of integration and co-production in action. The project provides joined up support for young people to access health care, putting their rights at the forefront and really focusing on removing barriers to health seeking behaviour. Members of the project outlined how the model is not easily replicated because it is so context and relationship specific but there are a number of core ingredients that would translate such as: partnership working, collaboration, relationships and an unwavering focus on the needs of the person (young people in this case). It was inspiring to hear about an example of GPs actively going out into the community to draw in those who would never normally access them.

7.2 **City of London** – I also recently spent a morning visiting the City of London with Simon Cribbens, Assistant Director of Partnerships and Commissioning and visited Goodman's Fields a new Tower Hamlets practice that takes in City residents as well as Neaman Practice. I also spent some time with a community group and Healthwatch at the Portsoken Community Centre which opened its doors in October 2021. It provides a range of activities for people of all ages living in the Portsoken ward of the City and focuses on encouraging resident participation as well as a range of activities including health and wellbeing.

7.3 **Whizz Kidz** – The final visit I would like to highlight was to WhizzKidz/Whizz mobility in Tower Hamlets. This is a great example of some of the integration we are trying to create. They provide the wheelchair services for Tower Hamlets and working closely with the ICB have created a service which is increasingly integrated with the local authority with joint funding so that both children and adults can have the wheelchair they need to support their health and care needs. It was great to meet the very passionate team, with an interesting self-management model, supported by commissioners in the ICB who they hold in high regard and who have really supported the integration journey. We have identified some funding to look in more detail at the model and its impact so we can share it with others across north east London, and hopefully others.

8.0 Corporate Objectives for 2023-24

I attach as an appendix to my report, the proposed corporate objectives for the financial year 2023-24. These build on the transitional objectives, agreed when the Board was first established in July 2022. The board is asked to agree these objectives for the next 12 months.

Zina Etheridge
March 2023

Corporate objectives for the NHS North East London ICB 2023-24

When the ICB was formally established on 1 July 2023 a set of transitional objectives were agreed by the board. These focused on ensuring the ICB delivered the purpose and priorities of ICSs: improving quality and outcomes, securing greater equity, creating value and deepening collaboration.

The transitional objectives were put in place ahead of a full set of strategic objectives for April 2023 and progress to date is as follows:

Transitional objective	Progress to date
Setting the foundations for our strategic objectives by establishing:	
• The five year strategy for the ICB	• An **interim ICP strategy** has been developed and a broad range of stakeholders and partners engaged and involved in this. The next step is to take this out to residents as part of the big conversation ahead of a revised version in the summer
• A finance strategy	• A **finance strategy** for the ICS is under development and has been tested and refined with partners and is now feeding in to the operating plan and work on the North East London Joint Forward Plan.
• A shared approach to population health and an approach to data and the digital infrastructure to support this, and enable us to tackle health inequalities	• Initial work is well underway and key governance is in place including the population health and integration committee and a health inequalities steering group co-chaired with a Director of Public Health and the ICB Chief Medical Officer. A robust plan is being developed through the ICP strategy and emerging joint forward plan.
• The policies we will need as an ICB to achieve our aims	• Work is ongoing to finalise key policies for the ICB but a number are already in place including a revised fertility policy for North East London, developed in collaboration with residents and stakeholders and ensuring an equitable approach for all local residents.
• Governance that enables and supports integration and focusses our collective effort on our objectives	• A **robust set of governance** has been established and implemented across the ICB via committee meetings and the overall Integrated care board, as well as place based meetings and the provider collaboratives. This is ensuring decision making and discussion is taking place regularly to deliver the overall objectives and priorities for the ICB and ICS.

Delivering a system operating plan	• A system operating plan is in development with the first submission complete. Further work is underway working in collaboration across the system. In addition a joint forward plan is being developed which will be the delivery vehicle for the overall strategy
Reshaping the way we work with a focus on co-production	• A participation strategy has been agreed including a number of core principles developed which the system is committed to delivering. A series of big conversation events are planned with residents for 2023 to ensure they are co-producing the overall strategy for the ICP.
Embedding clinical and professional leadership across the different parts of our system	• A model has been developed and agreed and recruitment is underway. All the place-based partnerships and Clinical Directors were in post from late Summer/Autumn 2022. Of the 128 total positions, 106 roles have been filled, with recruitment continuing into the outstanding posts and onboarding underway.
Focussing on our workforce	• A workforce strategy is being developed in collaboration across the system.

Corporate Objectives 2023-24

Building on the transitional objectives for 2023-24 and a continued commitment to delivering the core purpose of ICSs, a set of formal objectives for the board for the next financial year are proposed as follows:

1. **Implement the Integrated Care Partnership Strategy across places, collaboratives and system through the Joint Forward Plan. This will be achieved through:**
    - a continued commitment to delivering on the four system priorities:
        - Babies, children and young people
        - Long term conditions
        - Mental health
        - Local employment and workforce
    - a focus on six cross cutting themes:
        - Tackling health inequalities
        - 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
    - a focus on 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

2. **Deliver the NHS operational planning requirements and ensure we are delivering health and care services and effectively managing budgets** – through this plan we will ensure the elective recovery, mental health standards are met and that there is a joined up approach to demand, especially urgent and emergency care ensuing residents get the care they need.

3. **Develop a system wide workforce strategy** - enabling all of our workforce to achieve equitable access to services to support them, and putting in place the foundations for a shared strategic plan for a workforce across north east London that meets capacity gaps, ensures we have the new skills we need for the future and provides great employment opportunities for our residents.

4. **Develop and deliver on our commitment to being an anti-racist ICS**. Further to the London wide commitment to a strategic anti-racism approach in London's Health and Care System, North East London ICB will develop a robust action plan to include anti-racism training and establishing key networks to deliver on this commitment. To help close the health equity gaps across North East London and normalise race equality into being part of how our health and care system operates.

5. **Addressing health inequalities –** through effective population health management, robust data and effective digital approaches we will address the disparities that exist across North East London and ensure that we create meaningful improvements in health, wellbeing and equity, working with and for all the people of North East London.

6. **Working as a system** - having spent this year putting in place the key enablers for the ICS, there will now be a focus on putting in place the organisational development and culture of system working, ensuring it is systematically worked through and embedded

North East London
Integrated Care Board

NHS North East London ICB board

29 March 2023

Title of report	Joint Forward Plan – March submission
Author	Johanna Moss, Chief Strategy and Transformation Officer
Presented by	Johanna Moss
Contact for further information	johanna.moss1@nhs.net
Executive summary	Attached is a complete draft of our system's Joint Forward Plan – a five-year plan describing how we will, as a system, deliver our Integrated Care Partnership Strategy as well as core NHS services – and a supporting reference document providing further detail on the transformation programmes described in the main plan. We need to submit a draft of the plan to NHSE by the end of March, before further work and engagement across the system during April and May so that we can publish in June 2023. The plan will then be refreshed on an annual basis.
Action / recommendation	The Board is asked to provide comments on the plan and, subject to suggested changes, approve the plan for submission to NHSE.
Previous reporting	The Strategy Task and Finish Group is leading the development of the plan. Versions of the plan have also been discussed at the ICP Steering Group, NEL CEOs and Executive Management Team (feedback from these groups will be incorporated into the submission to NHSE but may not be reflected in the attached version).
Next steps/ onward reporting	During April-June engagement with system partners will take place, iterating the plan further, aligning programmes and identifying re-prioritisation required to support achievement
Conflicts of interest	None identified
Strategic fit	The JFP covers all our ICS aims: • 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 represents (at this stage) a consolidation of existing plans, rather than new plans. Any reprioritisation will be on the basis of engagement during April-June. An equalities impact assessment has not been undertaken at this stage.

Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report. The JFP represents (at this stage) a consolidation of existing plans, rather than new plans. Any reprioritisation will be on the basis of engagement during April-June.
Risks	Nationally dictated timescales mean that less engagement with system partners has been possible in the plan's development than would be ideal. The development team will endeavour mitigate this through a strong engagement plan for the next phase of work.

NHS
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NEL ICS Joint Forward Plan

March 2023

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1. Introduction

Introduction

- This Joint Forward Plan is north east London's first five-year plan since the establishment of NHS NEL. In this plan, we describe the challenges that we face as a system in meeting the health and care needs of our local people, but also the assets we hold within our partnership.
- We know that the current model of health and care provision in north east London needs to adapt and improve to meet the needs of our growing and changing population and we describe the substantial portfolio of transformation programmes that are seeking to do just that.
- The plan sets out the range of actions we are taking as a system to address the urgent pressures currently facing our services, the work we are undertaking collaboratively to improve the health and care of our population and reduce inequalities, and how we are developing key enablers such as our estate and digital infrastructure as well as financial sustainability.
- This is the first draft of our Joint Forward Plan and reflects that, as a partnership, we have more work to do to develop a cohesive and complete action plan for meeting all the challenges we face. We will work with local people, partners and stakeholders to iterate and improve the plan as we develop our partnership, including annual refreshes, to ensure it stays relevant and useful to partners across the system.

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

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

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

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

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

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

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

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

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

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

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

Improve quality & outcomes	Deepen collaboration	Create value	Secure greater equity

6 Crosscutting Themes underpinning our new ICS approach

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

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

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

Securing the foundations of our system

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

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

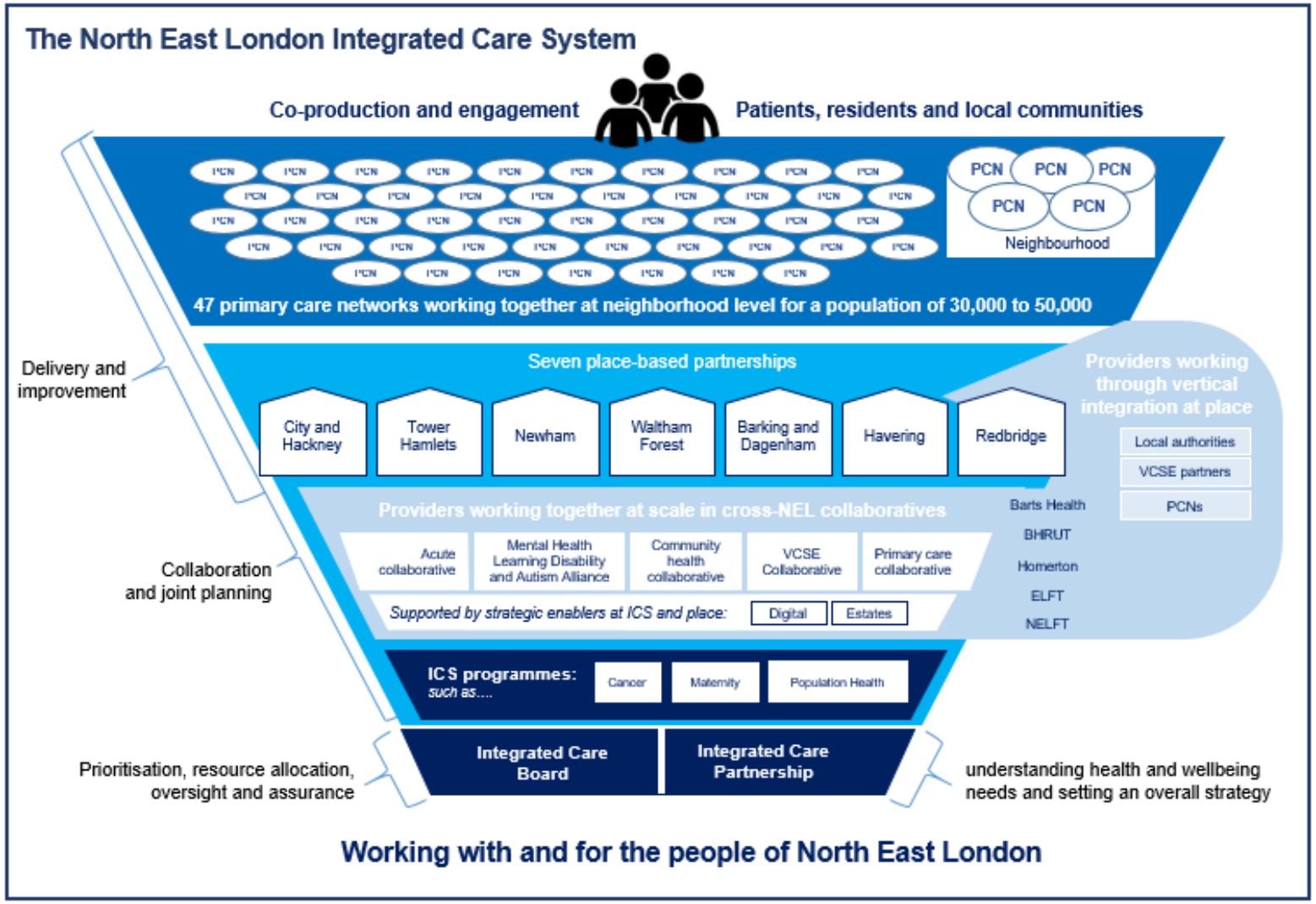
We are a broad partnership, brought together by a single purpose: to improve health and wellbeing outcomes for the people of north east London.

Each of our partners 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.



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North East London

2. Our unique population

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

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

Rich diversity

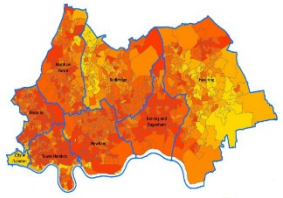
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from ethnic minority backgrounds.

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

Young, densely populated and growing rapidly

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

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



Poverty, deprivation and the wider determinants of health

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

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

Stark health inequalities

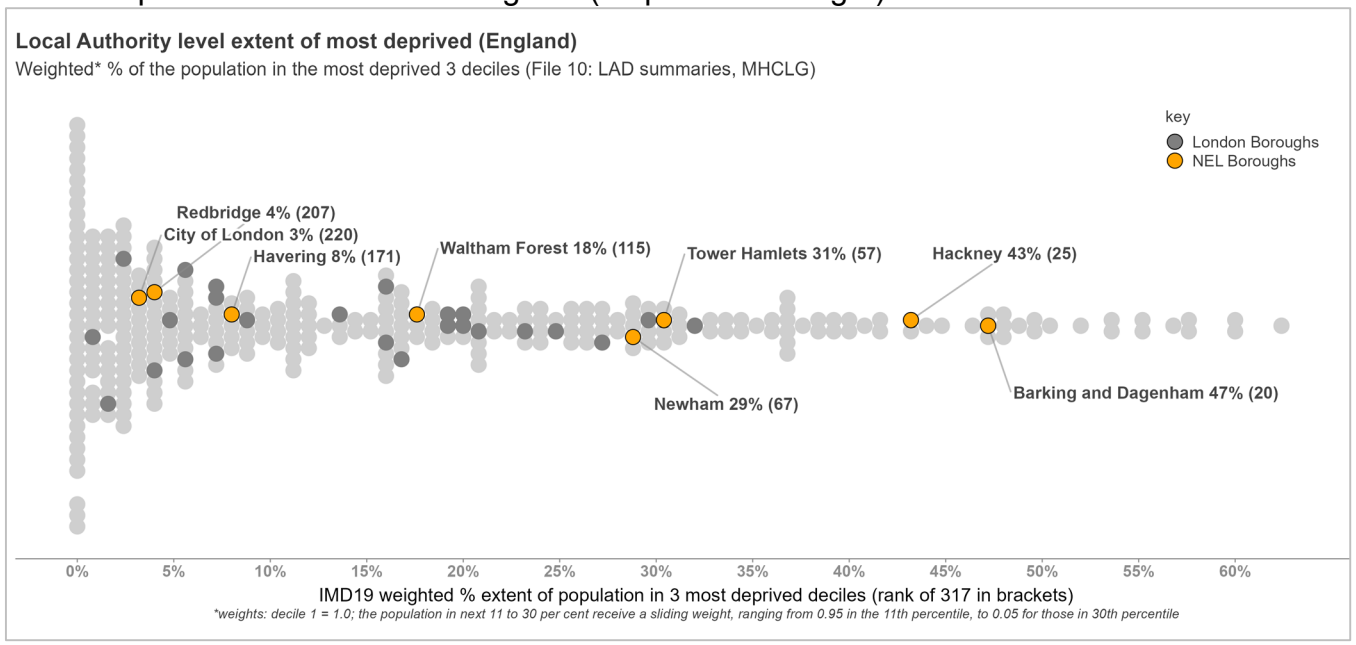
There are significant inequalities within and between our communities in NEL, and our population has worse health outcomes than the rest of the country across many key indicators. Health inequalities are linked to wider social and economic inequalities including poverty and ethnicity.

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

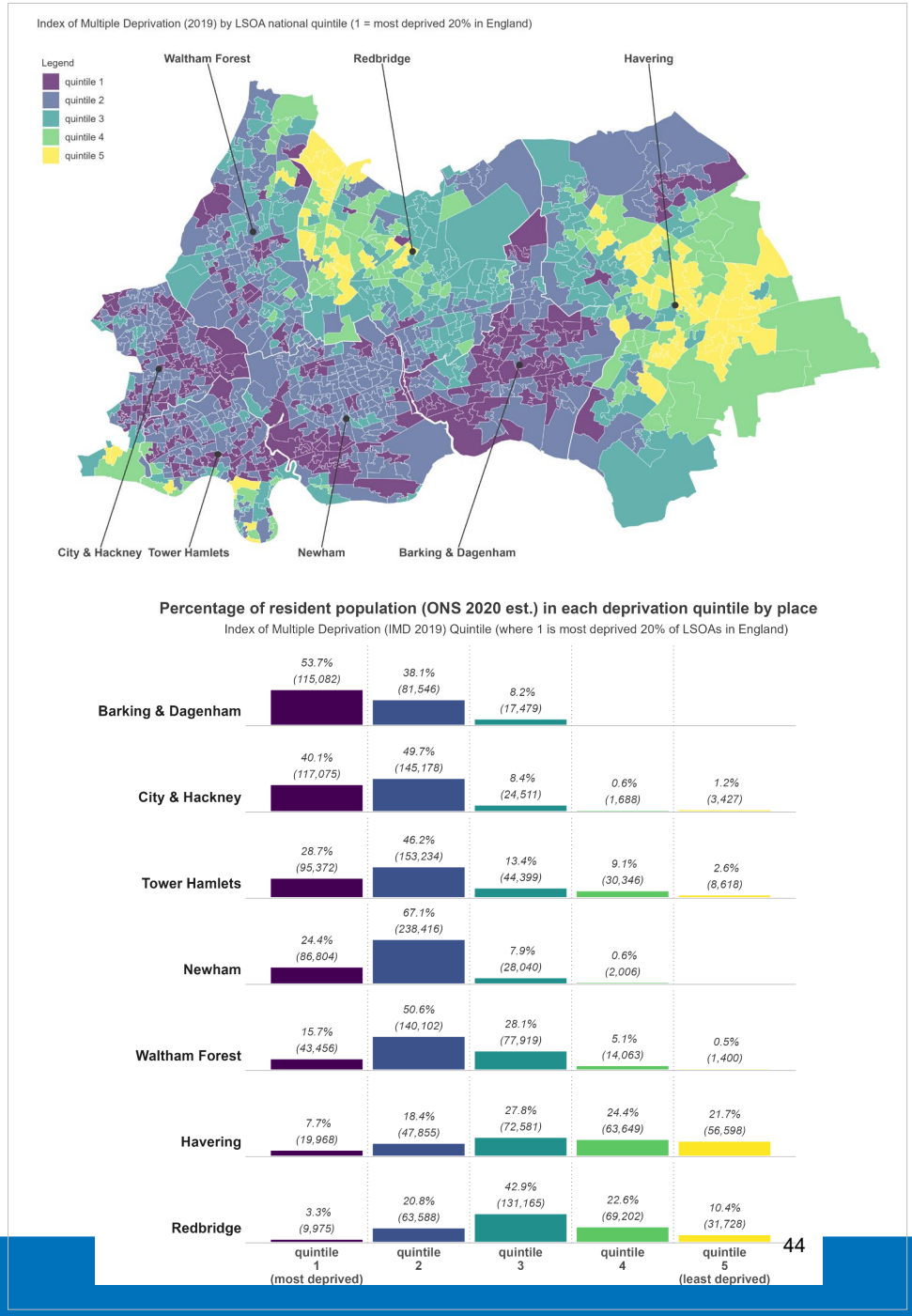
Key factors affecting the health of our population and driving inequalities - poverty, deprivation and ethnicity

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

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



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



The health of our population is worsening and we need a much greater focus on prevention, addressing unmet need and tackling health inequalities

Child Obesity

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

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

Mental Health

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

Tobacco

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

Premature CVD mortality

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

Vulnerable housing

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

Homelessness

Shelter estimate that there were 42,399 homeless individuals in NEL in 2022 including those in all kinds of temporary accommodation, hostels, rough sleeping and in social services accommodation: 1 in 47 people, compared to 1 in 208 people across England and 1 in 58 in London.

Childhood Poverty

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

Childhood Vaccinations

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

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

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

- For many conditions there are low recorded prevalence rates, while at the same time, most NEL places have a higher Standardised Mortality Ratio for those under 75 (SMR<75) – a measure of premature deaths in a population – compared to the England average. 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.
- Analysis of DNAs (people not attending a booked health appointment) in NEL has shown that these are more common among particular groups, for example at Whipps Cross Hospital DNAs are highest among people living in deprived areas and young black men. Further work is now happening to understand how we can better support these groups and understand the barriers to people attending appointments across the system.

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

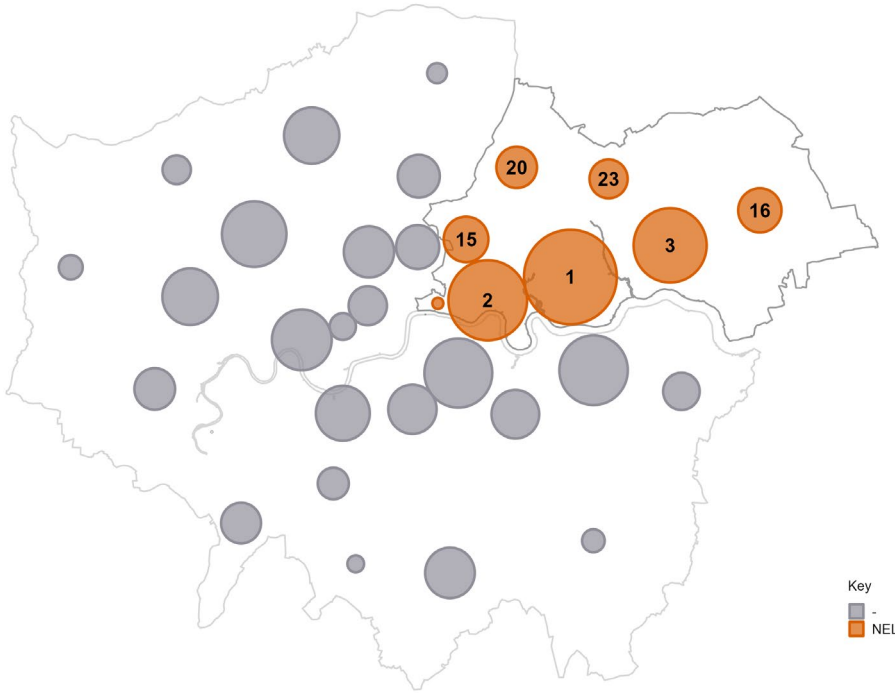
The population of north east London (currently just over 2 million) is projected to increase by almost 15% (or 300k people) between 2023 and 2040, the equivalent to adding a whole new borough to the ICS, and by far the largest population increase in London.

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

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

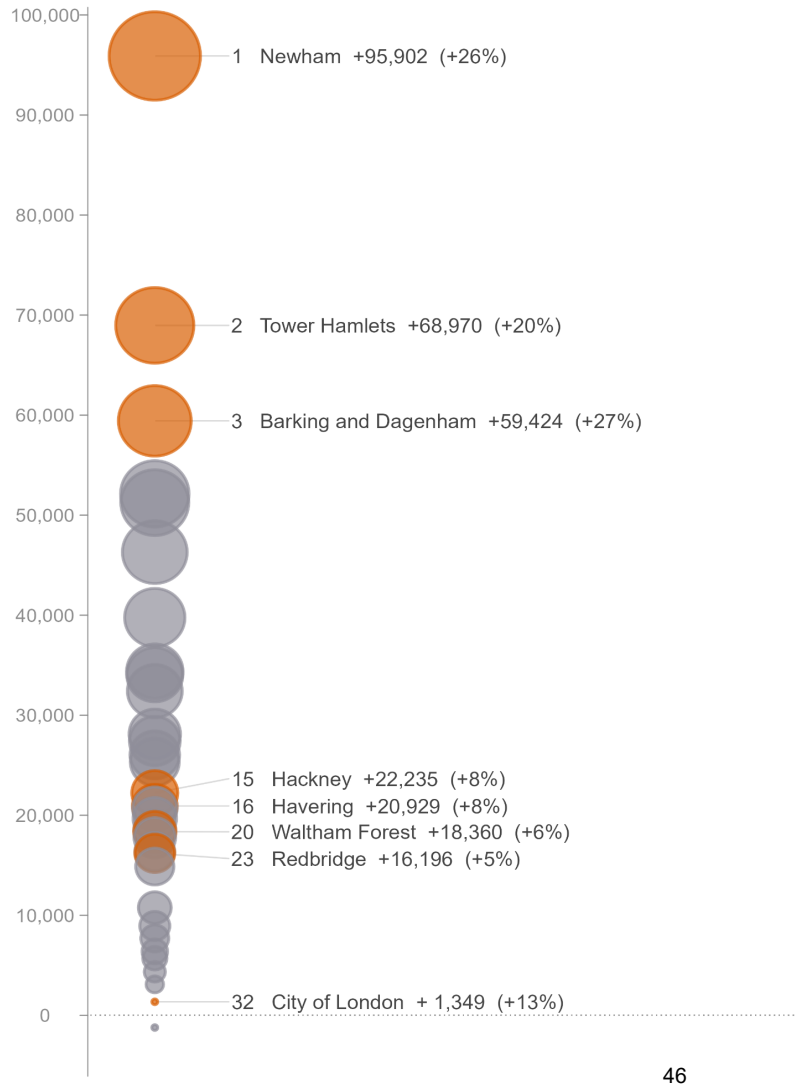
In addition, the age profile of our population is set to change over the coming years. Our population now is relatively young, however, some of our boroughs will see high increases in the number of older people in the coming years as well as increasing complexity in overall health and care needs.

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



GLA Identified Capacity Scenario, published September 2021, 2020 based

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



GLA Identified Capacity Scenario, published September 2021, 2020 based

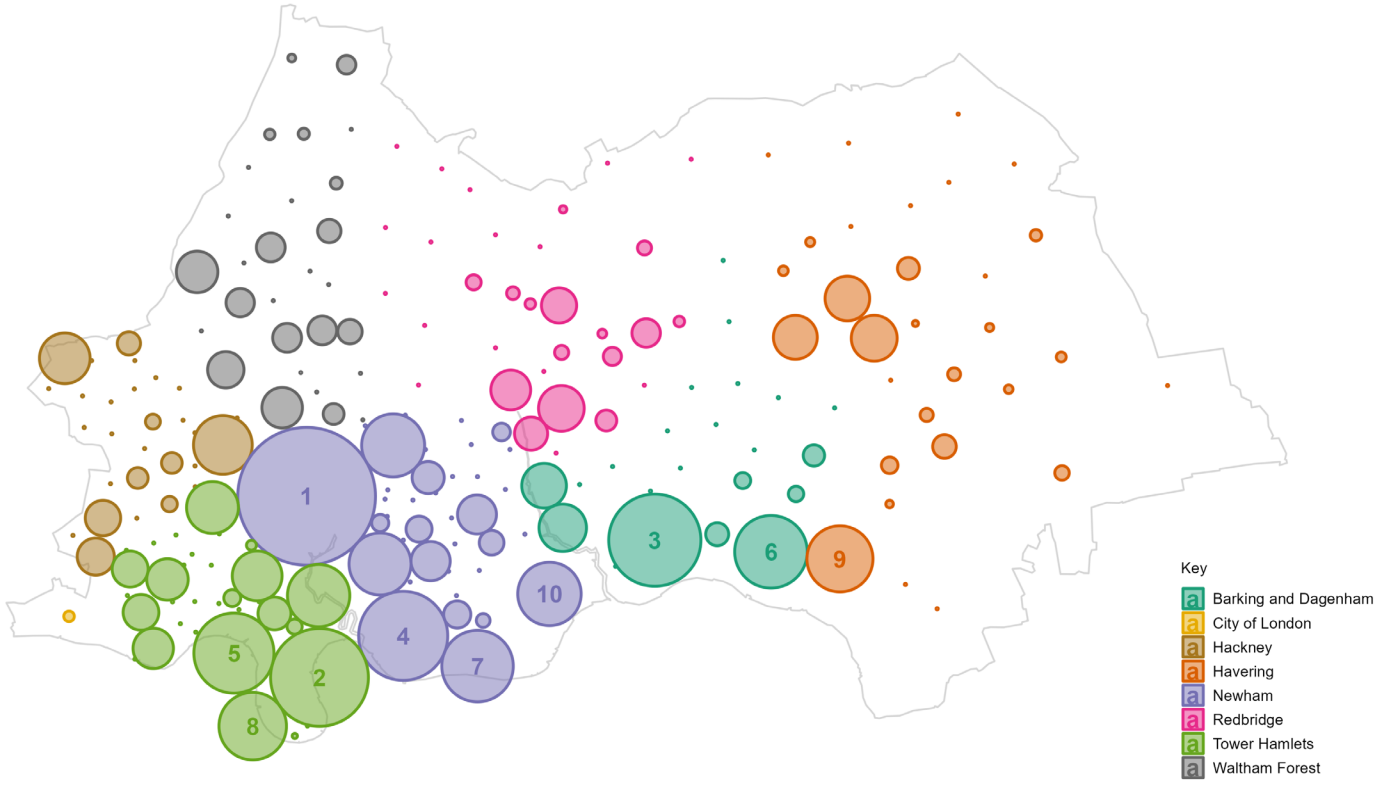
We need to act urgently to improve population health and address the impact of population growth

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

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

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

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



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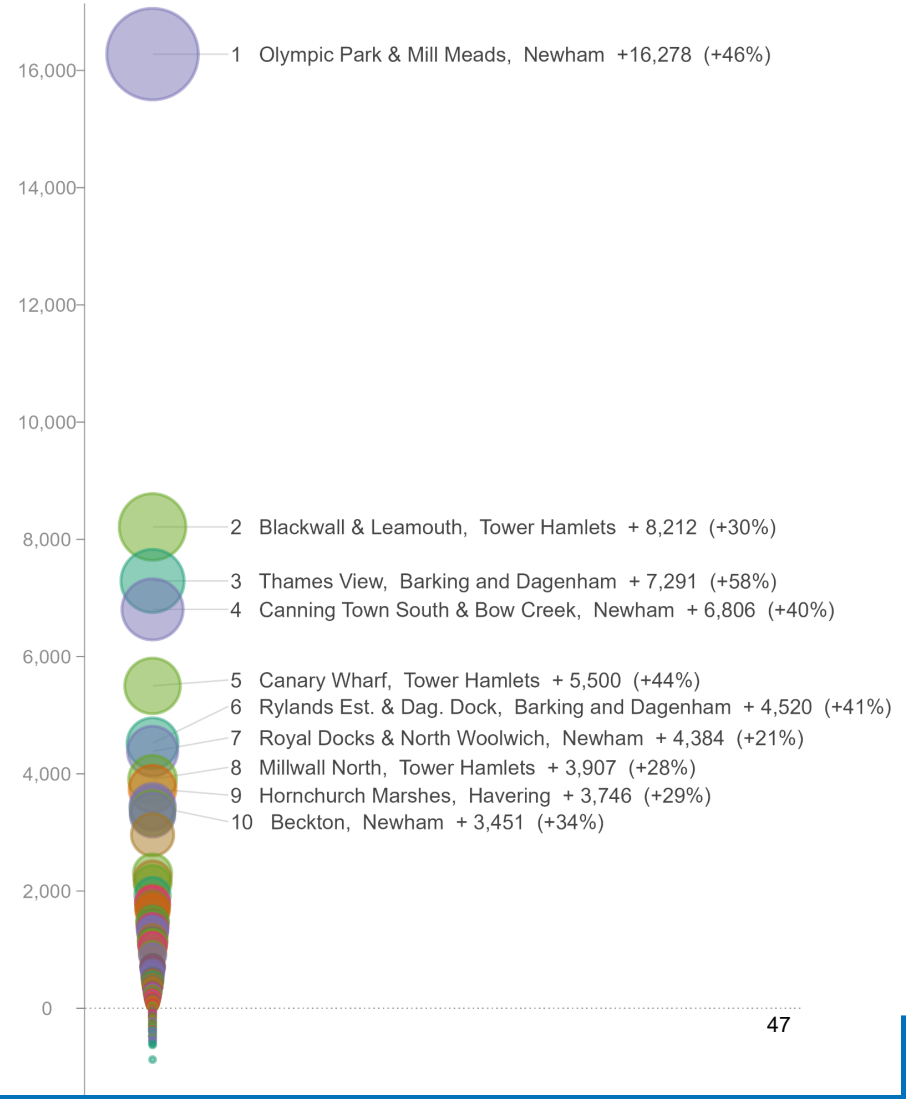
NEL neighbourhood (MSOA) all age population increase 2023-2028

Labelled circles = top 10 NEL neighbourhoods by population increase



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3. Our assets

We have significant assets to draw from

£ figures to be confirmed prior to submission

North east London (NEL) has a growing population of over 2 million people and is a vibrant, diverse and distinctive area of London steeped in history and culture. The 2012 Olympics were a catalyst for regeneration across Stratford and the surrounding area, bringing a new lease of life and enhancing the reputation of this exciting part of London. This has brought with it an increase in new housing developments and improved transport infrastructure and amenities. Additionally the area is benefiting from investment in health and care facilities with a world class life sciences centre in development at Whitechapel and confirmed funding for the Whipp's Cross Hospital redevelopment. There are also plans for a new health and wellbeing hub on the site of St George's Hospital in Havering, making it an exciting time to live and work in north east London.

Our assets

- **The people of north east London** – who bring vibrancy and diversity, form the bedrock of our partnership, participating in our decisions and co-producing our work, they are also our workforce, provide billions of hours of care and support to each other and know best how to deliver services in ways which work for them.

- **Research and innovation** – Continuously improving, learning from international best practice and undertaking from our own research and pilots to evidence what works for our diverse communities/groups. We want to build on our work, strengthen what we have learnt to provide world-class services that will enhance our communities for the future.

- **Leadership** – our system benefits from a diverse and talented group of clinical and professional leaders who ensure we learn from and implement the best examples of how to do things, innovate and use data and evidence in order to continually improve. Strong clinical leadership is essential to lead communities, support us in considering the difficult decisions we need to make about how we use our limited resources and help set priorities that everyone in NEL is aligned to. Overall our ICS will benefit from integrated leadership spanning senior leaders to front line staff who know how to make things happen, the CVS who bring invaluable perspectives from ground level, and residents who know best how to do things in a way which will have real impact on people.

- **Financial resources** – we spend nearly £4bn on health services in NEL, around £2bn on services provided by local authorities, as well as an additional nearly £2bn again on schools as well as resources brought in by the CVS. By thinking about how we use these resources together, in ways which most effectively support the objectives we want to achieve at all levels of the system, we can ensure they are spent more effectively and in particular in ways with improve outcomes and reduce inequality in sustainable way.

- **Primary care** - is the bedrock of our health system and we will support primary care leaders to ensure we have a multi-disciplinary workforce, which is responsive and proactive to local population needs and focused on increasing quality as well as supported by our partners to improve outcomes for local residents.

Our health and care workforce is our greatest asset

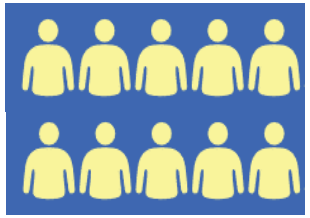
To be updated during April-June in line with People Strategy currently under development

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

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

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

Our ICS People Strategy will ensure there is a system wide plan underpinning the delivery of our new Integrated Care Strategy and Joint Forward Plan focused on increasing support for our current workforce, strengthening the behaviours and values that support greater integration, and collaboration across teams, organisations and sectors and contributing to the social and economic development of our local population through upskilling and employing more local people.



There are almost one hundred thousand staff working in health and care in NEL; and our employed workforce has grown by 1,840 in the last year.

Our workforce includes -

- Over 4,000 people working in general practice with 3.7% growth in our workforce over the last year
- 46,000 people working in social care
- 49,000 people working in our trusts

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

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

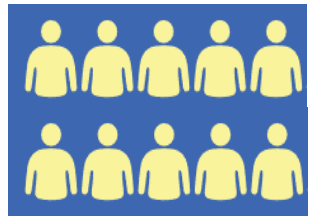
In NEL we are supporting the development of a VCSE Collaborative to create the enabling infrastructure and support sustainability of our rich and diverse VCSE in NEL, also ensuring that the contribution of the VCSE is valued equally.

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

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

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

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



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

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

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4. Our challenges and opportunities

The key challenges facing our health and care services

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

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

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

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

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

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

We face substantial pressures on same day urgent care

Key messages	*Detail*
Demand for same day urgent care is growing rapidly as NEL's population grows	• Demographic and non-demographic changes to the NEL population are projected to increase demand for A&E attendance and unplanned admissions by 15-16% over the next 5 years.
The status quo isn't viable. Doing more of the same will exacerbate existing pressures	• We have significant performance challenges across all three acute trusts (e.g. average 60% on four hour A&E target) • Growing demand for unplanned care within acute settings risks undermining efforts to reduce backlogs of patients waiting for planned care
Improvements in care pathways, including a shift of system resource to out of hospital services (primary and community care), could help reduce demand for expensive unplanned acute care for some patients	• Rates of avoidable admissions (for conditions that ought to be manageable through better primary care) are high at a large number of primary care practices within NEL (between 37 and 46 depending on the type of avoidable admission) • Mental Health patients are facing long waits in A&E (around 4,500 are expected to have waited more than 12 hours during 22/23) • Non-conveyance from ambulance calls to care homes vary considerably and represent a higher proportion than the London average • Around 13% of A&E attendances leave without any significant investigation or treatment suggesting they could have been better managed elsewhere in the system
Patients on waiting lists are causing pressures across other parts of the system	• A snapshot of the current elective waiting list indicates that 14% of the patients waiting for elective care have been responsible for 47,000 A&E attendances during their wait
There is an opportunity for improving UEC from better system working	• An analysis of NEL against other London ICSs indicates that moving to the median ICS performance for non-elective admissions would see a reduction of around 10%. This would be a substantial contribution to closing the projected gap created by growing demand and equates to around £65m per year

We have a large backlog of people waiting for planned care

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

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

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

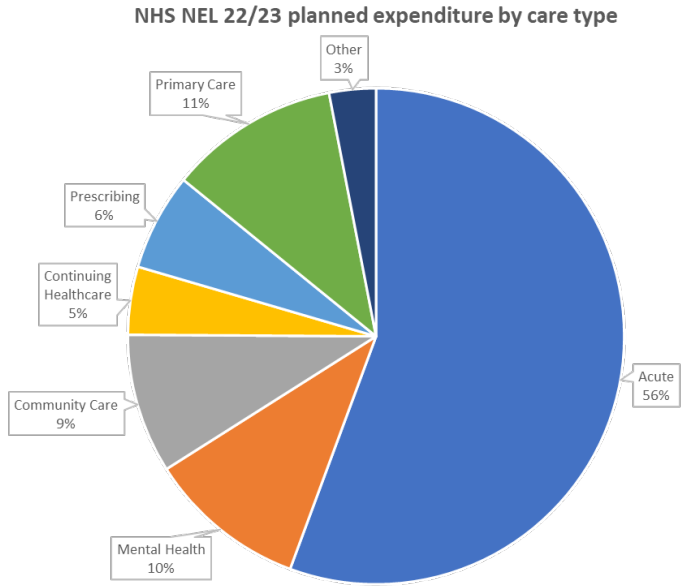
- North east London currently has relatively few GP appointments per 100,000 weighted population (39,244 vs a median for all ICSs of 42,360 – i.e. the national median is around 8% greater than in NEL), suggesting part of the cause of pressure on other parts of the system, including greater than expected non-elective admissions at the acute providers, may be due to insufficient primary care capacity.
- The variation of clinical care encounters per week (all appointment types) varies from 79.85 per '1000 patients in Waltham Forest to 58.43 per '1000 patients in Barking and Dagenham, with the NEL average being 69.43 per '1000 patients.
- Without substantial increases in primary care staffing the GP:patient ratio will worsen as demand for primary care encounters (a broader measure of patient interaction with clinical primary care staff than GP encounters alone) are set to increase by 15% across north east London over the next 5 years, with growth in Newham as high as 19%.
- There are pockets of workforce shortages with significant variation in approaches to training, education, recruitment and retention.
- Community care in north east London is currently fragmented, with around 65 providers offering an array of community services. More work is required to understand the impact this has on patient outcomes and variability across NEL's places, but we know that for pulmonary rehab, for example, there is variation in service inclusion criteria and the staffing models used, and that waiting times vary between 35 and 172 days, with completion rates between 36% and 72% across our places and services.
- More children and young people are on community waiting lists in NEL than any other ICS (NEL is about average, across England, for the number of people on adult community waiting lists).
- There are opportunities to build on our best practice to further develop integrated neighbourhood teams, based on MDTs, social prescribing and use of community pharmacy consultation services, which will strengthen both our continuity of care of long term conditions and our ability to work preventatively.

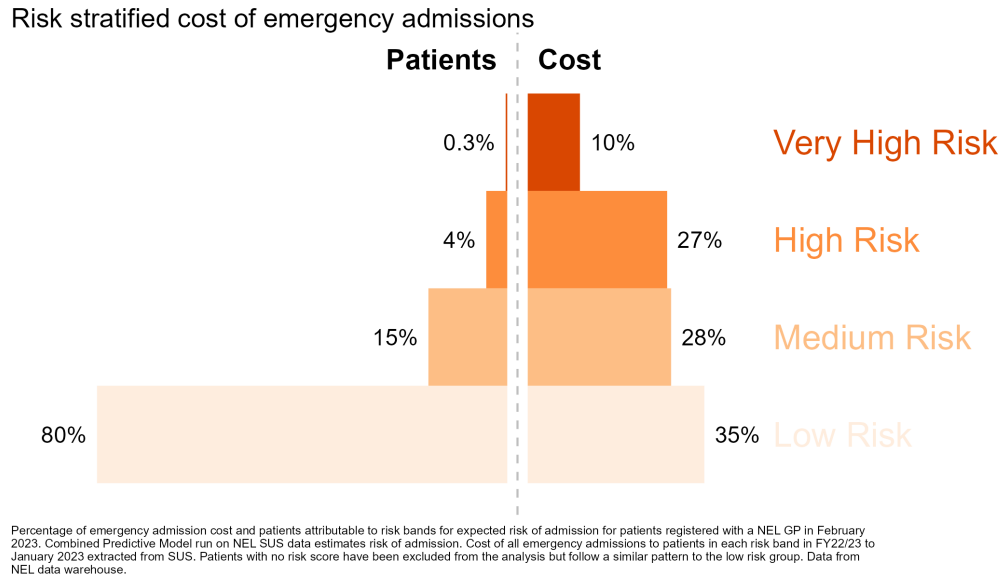
Long term conditions

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

We need to move away from the current blend of care provision as this is unaffordable

- The system has a significant underlying financial deficit, held within the trusts and the ICB. Going into 2023/24 this is estimated to be in excess of £100m. This is due to a number of issues, including unfunded cost pressures.
- Current plans to improve the financial position, such as productivity/cost improvement programmes within the trusts, are expected to close some of this financial gap and we know there are opportunities for reducing unnecessary costs, such as agency spend – in NEL agency spend is 7% of total spend vs 4% median for London ICSs.
- In addition to a financial gap for the system overall, there are also discrepancies between how much is spent (taking into account a needs-weighted population) across our places, in particular with regard to the proportion spent on out of hospital care.
- The system receives a very limited capital budget (of around £90m), significantly less than other London ICSs (which receive between £130m-£233m) and comparable to systems with populations half the size of NEL*. This puts significant pressure on the system and its ability to transform services, as well as maintain quality estate.
- There is huge variation in the public health grant received by each of NEL's local authorities from central government – ranging from £114 per person in City and Hackney to £43 per person in Redbridge. The variation is at odds with the government's intended formula (which is based on SMR<75) and is the result of grants largely being based on historical public health spend. Barking and Dagenham has the highest SMR<75 of any borough in London, yet receives only £71 per person. Havering has the same SMR<75 as Tower Hamlets (97) yet Havering receives £45 per person, whereas Tower Hamlets receives £104 per person. This significantly impacts on our ability to invest upstream in preventative services.
- As a system the majority of our spend is on more acute care and we know that this is driven particular populations (0.3% of the population account for 10% of costs associated with emergency admissions; just under 20% account for 65%).





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

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

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5. How we are transforming the way we work

Current plans are a first step towards building a sustainable, high quality health and care system, but we know there is more to do

We recognise that existing programmes will not be sufficient to meet all the challenges we face as a system, we therefore intend to use this plan to identify the gaps and to engage system partners and our local people on how best to redirect limited resources to have greatest impact

1	A description of the major transformation programmes underway across north east London, setting out the benefits for residents, how the work addresses inequalities, key features and milestones, and what transformation in the area will need to include over the longer term	Covered in this Joint Forward Plan (March submission)
2	Analysis of where our current transformation portfolio aligns with our integrated care partnership's strategy, our operating plan, and the challenges set out in earlier sections of this joint forward plan;	
3	Identification of the gaps in the coverage of the transformation portfolio and also where any current transformation work does not fully align with current system challenges and ambitions	To be developed through engagement with system partners and local people — April-June
4	How our system transformation portfolio should evolve and re-prioritise – in terms of the deployment of financial and people resources – to ensure that it delivers greatest benefits for local people	To be developed through engagement with system partners and local people — June onwards
5	Develop and evolve our plans and how we work together as a system – in particular partners responsible areas that impact our population's health, but sit outside the health and care system, such as Housing – to better align partners in the best interests of local people	Plan continues to be developed and iterated, with annual refreshes

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

- The previous section set out the challenges that the north east London health and care system needs to address to succeed in its mission to create meaningful improvements in health and wellbeing for all local people
- North east London's portfolio of transformation programmes has evolved organically over many years: rooted in the legacy CCGs and sub-systems, then across the system through the North East London Commissioning Alliance and the single CCG, and now supplemented by programmes being led by our place partnerships, provider collaboratives, and NHS NEL.
- It has never previously been shaped or managed as single portfolio, aligned to a single system integrated care strategy.
- As part of moving to this position, this section of the plan baselines the system portfolio with programmes set out according to common descriptors – providing a single view never previously available across the system, with the scale of the investment of money and staff time in transformation clearer than ever before.
- This section sets out how partners across north east London are responding to the challenges described in the previous section. It describes how they are contributing to our system priorities by considering four categories of improvement

1. Our core objectives of high-quality care and a sustainable system

2. Our NEL strategic priorities

3. Our supporting infrastructure

4. Local priorities within NEL

A quick snapshot of NEL's transformation work

- The next part of this plan contains summary information about existing transformation programmes, with full detail of all programmes contained in the reference pack accompanying this plan.
- Some highlights of the portfolio that will deliver during 2023/24 include:

By April 2024

- equitable access to cardiac rehabilitation services for all eligible local people
- new community diagnostic centres open in Barking and Mile End
- a seven-day-a-week transient ischemic attack (mini-stroke) service
- two home-from-home haemodialysis (kidney dialysis) stations in the East London Mosque
- almost one thousand local people supported by urgent community response services
- mobilisation of a digital framework for community and social care providers to enable greater interoperability and so joined up care
- consistent medicines reviews and oral checks for all residents in care homes
- three family hubs in Barking and Dagenham
- equal access to palliative end-of-life care services for all local people
- access to specialist post-covid services in less than four weeks from GP referral
- wellbeing and mental health support in all City and Hackney schools
- the new St George's health and wellbeing hub open in Hornchurch
- an infrastructure plan for Newham to meet the challenge of population growth over twenty years
- new services supporting thousands of inpatients to stop smoking
- a concerted drive to improve performance and quality in general practices with CQC ratings of 'inadequate' or 'requires improvement'
- all general practices incentivised to deliver enhanced care to local people with long-term conditions
- 300 additional personal health budgets for people with serious mental illness
- 1,000 active users of the Patient Knows Best patient-held record
- the new Ilford Exchange Health and Care Centre open to local people

Urgent and emergency care

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Reduced ambulance conveyances to EDs
  - No ambulance handovers over 60 mins
  - Increased access to Same Day Emergency Care (SDEC) across Acute sites
  - Constituently meeting 70% + UCR target NEL target is 90% meet trajectory count of 9995 residents supported 23/24
  - Implementation of virtual ward interfaces and more digital interoperability
- April 2026:
  - Increased and new community medicine pathways to support out of hospital arrangements where appropriate
  - Increased access via digital to support access to services ie bookable urgent appointments
  - Pipeline of U&EC workforce with clear career/ skills development opportunities across NEL
  - Expansion of UCR service offer more support for identified residents as high intensity users
  - More mobilisation of digital enabled technology for delivery of UCR

How this transformation programme reduces inequalities between north east London's residents and communities:

- Increasing equity of access across the geography (front door streaming, SDEC access, optimising pathway 0)
- Through the ambulance flow workstream, working with ambulance Providers, to support Frailty pathways
- Support to patients with Learning Difficulties and Autism accessing U&EC services
- Collaborative working with the Mental Health Collaborative on U&EC pathways for patients

Key programme features and milestones:

- U&EC Programme aim to improve equity of access to non-elective care for the population of NEL
- Workstream focus on:
  - REACH and PRU sustainability and development
  - Ambulance flow
  - 'front door' working with UTCs
  - SDEC
  - U&EC workforce - newer roles and CESR training programme
  - Urgent diagnostic access
  - Optimising pathway 0.
- 9995 residents supported by the end of 23/24 in accordance with trajectory for the service
- Electronic Single Point of access pull Pilot to increase count of residents accessing the service via 111/999 triage

Further transformation to be planned in this area:

Over the next two years

- Keeping people safe and well at home: virtual wards, effective falls response, anticipatory care, etc
- Access to real-time information across the system to support forecast/ demand management
- Join up pathways including access to UCR virtual wards with existing pathways to maximise

Over years three to five

- Further development of virtual consultations for U&EC

Programme funding:

- See reference pack for details
- SDF funding
- NHSE funding

Leadership and governance arrangements:

- APC U&EC monthly Programme Board
- Community Based Care
- Task & Finish Groups for Delivery Oversight with providers
- Operations Working Group – Trajectory, Capacity and Delivery Monitoring

Key delivery risks currently being mitigated:

- Funding requests not yet approved, impacting on the ability tot delivery the full programme of work, ICB prioritisation may be required
- Variation of the way service is configured across NEL provision
- Comms and engagement to promote the service - need additional support so care homes, primary care and other parts of system think UCR first
- Digital connectivity with LAS / UCR – this will be explored in Pilot

Alignment to the integrated care strategy:									
Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Community health services

The benefits that north east London residents will experience by April 2024 and April 2026:

- April 2024:
  - greater digital interoperability and one shared record to include universal care plans, which enables more joined up care across providers
  - standardisation of access to palliative care services across north east London
  - access to post-covid rehabilitation within four to ten weeks of persistent ongoing symptoms and access to specialist services within four weeks of GP referral
  - proactive care assessments for residents with two or more long-term health conditions
  - at least 551 virtual ward beds with an integrated acute and community provision model
- April 2026:
  - a shared care record for health and special care, leading to better feedback loops for residents
  - two thousand generalist staff trained on a range of palliate care delivery areas
  - standardisation of quality of and access to palliative care services across north east London
  - post-covid care is part of a business as usual offer within community provision
  - an equitable offer of proactive care across north east London

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing barriers to care for local people through further roll-out of the shared care record across care homes and social care providers
- By equalising the digital offer to local people across north east London
- By co-designing digital tools with local people from across north east London's communities
- By ensuring a representative sample of local people's voices participate in service design
- By increasing patient choice, with personalised care through digital tools where applicable

Key programme features and milestones:

- Building equitable care offers for all local people Patient empowerment through improved access to data
- Better care through improved data sharing and digital operability across health and social care providers
- Deep and continuous resident engagement and co-production
- Ongoing dialogue and strengthening of relationships with Healthwatch and the voluntary, community and social enterprise sector

Further transformation to be planned in this area:

- Over the next two years
  - rollout of universal care plan and shared care records
  - for proactive care, establishing the local population health cohort of at-risk residents
  - bereavement service accessible by all local people
- Over years three to five
  - integrating proactive care with hospital discharge processes to reduce avoidable readmissions
  - integrated workforce tools across health and care

Programme funding:

- See reference pack for details: System Development fund, National Ageing Well funding, Virtual ward funding, NHS England funding for shared care records and EPR

Leadership and governance arrangements:

- Community collaborative and individual programme governance – under development
- interfaces with relevant provider collaborative governance and NHS NEL

Key delivery risks currently being mitigated:

- Uncertainty of some medium-term funding
- Information governance issues around care records
- Workforce availability and capacity
- Current inequities of funding across places

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Primary care

The benefits that north east London residents will experience by April 2024, April 2026, and April 2028:

- April 2024:
  - ➢ improved digital access, including through remote consultations, the NHS app, improved website quality, and e-Hubs
  - ➢ all practices offering core and enhanced care for people with long-term conditions to a minimum NEL-wide standard
  - ➢ additional services from community pharmacies
- April 2026:
  - ➢ all practices will be CQC rated as GOOD or have action plans to achieve this
  - ➢ further equalisation of enhanced services
- April 2028
  - ➢ streamlined access to a universal same-day care offer, with the right intervention in the right setting and a responsive first point of contact

How this transformation programme reduces inequalities between north east London's residents and communities:

- By tackling the digital divide between local people – and resulting inequalities – through the recruitment of Digital Champions across north east London
- By equalising the use of – and therefore local people's access through – digital tools by all practices and primary care networks
- By providing the same access to primary care for all local people, irrespective of where they live in north east London
- By levelling up the overall quality of primary care in north east London, as shown through CQC ratings
- By better understanding local population need and inequalities through improved practice coding

Key programme features and milestones:

- LIS and LES equalisation programme
- EQUIP's *Understanding demand* programme
- Local primary care teams working with practices on local variation
- Promoting use of online and video consultation through engagement sessions with local people
- The same-day access programme is in its design phase, based on the key principles of: a clearly defined service offer, intuitive access points, the availability of self-care approaches, self-referral to community services, and innovative services in the community
- The scope of the same-day access programme covers primary care same-day access, 111 services, and urgent treatment centres

Further transformation to be planned in this area:

- Over the next two years
  - ➢ Further digital enabling of social prescribing, community pharmacy, care homes, and UEC
  - ➢ Improved understanding of demand and capacity through digital tools
  - ➢ Further improvement of same-day services
  - ➢ Better understanding of inequalities at place and PCN level

Programme funding:

- For Digital First: £1.9m for 2022/23; TBC for 2023/24
- For same-day access, from core ICB service funding

Leadership and governance arrangements:

- interfaces with relevant provider collaborative governance, the ICB UEC board and the Fuller Oversight Board
- Digital First Board

Key delivery risks currently being mitigated:

- Uncertainty of ongoing funding for Digital First, including national online consultation licence
- Availability of funding to deliver equalisation of the long-term condition enhanced care offer
- Workforce capacity to deliver new services
- Teams' capacity to deliver change
- Digital operability
- Variation of stakeholder participation across NEL

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Planned care and diagnostics

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Waiting times for elective care are reduced so that no one is waiting more than 52 weeks
  - Improved equity of access to diagnostic and elective care through creation of Community Diagnostic Centres in Mile End & Barking, surgical capacity at KGH and NUH and ophthalmology in Stratford
  - Reduced unwarranted variation in access to 'out of hospital' services
- April 2026:
  - Waiting times for elective care are reduced in line with national requirements moving towards a return to 18-week referral to treatment standard.

How this transformation programme reduces inequalities between north east London's residents and communities:

- By April 2024, we will have reduced the variation in waiting times that exists between acute providers for elective care
- By April 2024 we will have increased the availability of 'Advice & Refer' services via GPs to residents
- By April 2024 we will have reduced the variation in community/out of hospital service access across NEL specifically in ENT, MSK, dermatology, gynaecology & ophthalmology
- By April 2024 residents and communities able to access community diagnostic services in Barking and Mile End.

Key programme features and milestones:

The Planned Care Recovery & Transformation portfolio is designed to meet national requirements for recovering & transformation elective care services. In NEL, this will mean delivering reduction in waiting times and importantly reducing the variation in access that exists. The portfolio of work covers the elective care pathway from referral to treatment

Key milestones include:

- Development of single NEL community/out of hospital pathways
- CDCs in Barking & Mile End
- Ophthalmic outpatient/diagnostic/surgical centre-Stratford
- Additional theatre capacity in Newham, Ilford & Hackney.

Further transformation to be planned in this area:

- Over the next two years
  - Development of referral optimisation tools across NEL
  - Review for all contracts for out of hospital services
  - Increasing use of Advice & Guidance/Refer, Patient Initiated Follow-up (PIFU)
- Over years three to five
  - On-going development/implementation of transformation programmes to reduce the variation in equity of access

Programme funding:

- The programme is resourced from the ICB & acute trusts
- Theatre expansion from Targeted Investment Fund
- CDC national capital & revenue funds

Leadership and governance arrangements:

- Planned Care Recovery & Transformation Board & associated sub-committees
- APC Executive & Board
- Clinical Leadership Group in high volume surgical specialities

Key delivery risks currently being mitigated:

- Workforce –ability to recruit required workforce to fill exist -ing vacancies, creation of CDCs & expansion of theatres.
- Digital – Digital transformation linked to service transformation
- Access to transformation funding to test new care models
- Inflationary pressures on building costs

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention		Co-production		Learning system	

Cancer

The benefits that north east London residents will experience by April 2024 and April 2026:

- April 2024:
  - Access to Targeted Lung Health Check service for 40% of the eligible population
  - Access to prostate health check clinic for those with a high risk
  - Implementation of Lynch Syndrome pathways and Liver surveillance
- April 2026:
  - Earlier detection of cancer
  - Improved uptake of cancer screening
  - Every person in NEL receives personalised care and support from cancer diagnosis

How this transformation programme reduces inequalities between north east London's residents and communities:

- By March 2024 The programme will reduce health inequalities in accessing cancer screening and early diagnosis by tailoring interventions to specific audiences
- By March 2024 The programme will undertake innovative research such as the Colon Flag programme to identify patients patients who may have cancer earlier
- By March 2024 Early diagnosis work on Eastern European and Turkish populations as well as engaging with Roma and Traveller communities.
- By March 2024 Health and wellbeing information provided in various formats / languages, support for patients who do not use digital and support for people with pre-existing mental health problems

Key programme features and milestones:

The programme consists of projects to improve diagnosis, treatment and personalised care.
Key milestones to be delivered by March 2024 include:
BPTP milestones in suspected prostate, lower GI, skin and breast cancer pathways delivered

- National cancer audit implementation
- TLHCs provided in 3 boroughs with an agreed plan for expansion in 2024/25
- Cancer Alliances' psychosocial support development plan delivered
- Develop and deliver coproduced quality improvement action plans to improve experience of care.

Further transformation to be planned in this area:

- Over the next two years
  - Support the extension of the GRAIL interim implementation pilot into NEL.
  - Implement pancreatic cancer surveillance for those with inherited high risk.
  - Evaluate impact that rehabilitation interventions has on patient outcomes and efficiencies i.e. reducing length of stay and emergency admissions.
- Please note that Cancer Alliance Programme is currently funded nationally until March 2025.

Programme funding:

- *Overall sum and source: Cancer alliance funded by NHSE*

Leadership and governance arrangements:

- Programme Director Archna Mathur; Lead Femi Odewale
- Cancer board – internal assurance
- Programme Executive Board – NEL operational delivery
- APC Board and National / Regional Cancer Board

Key delivery risks currently being mitigated:

- Imaging delays in scanning and reporting (affecting backlog)
- Histopathology reporting turnaround time
- Recruitment of targeted lung health staff at Barts Health
- implementing a stratified pathway into primary care
- RMS delays at Homerton/ BHRUT are due to workforce capacity and PCC leads vacancy

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	

Maternity

The benefits that north east London residents will experience by April 2024 and April 2026:

- April 2024:
  - Improved access to postnatal physiotherapy for women experiencing urinary incontinence
  - Reduced unwanted variation in the delivery of care (through the regional service specification)
  - Increased breastfeeding rates, especially amongst babies born to women living in the most deprived areas
- April 2026:
  - The majority of women are offered Midwifery Continuity Care
  - A single digital system across NEL for maternity care records
  - Improved post-natal care to support areas such as reduction in smoking, obesity, and other public health concerns
  - Better integrated maternity and neonatal services and improved interface with primary care

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing stillbirth, maternal mortality, neonatal mortality, and serious brain injury in women and babies from BME background and women from deprived areas.
- By closely aligning maternity and neonatal care to deliver the best outcomes for women and their babies who need specialised care
- By improving personalised care for women with heightened risk of pre-term birth, including for younger mothers and those from deprived backgrounds
- By ensuring that all providers have full baby-friendly accreditation and that support is available to those living in deprived areas who wish to breastfeed their baby

Key programme features and milestones:

- Delivering key maternity safety actions
- Achieving the Ockenden Essential Actions in collaboration with the Neonatal Operational Delivery Network
- Supporting the recommendations of the Neonatal Critical Care Review
- Facilitating and supporting leadership cultural development
- Supporting the recruitment, retention and well-being of maternity workforce
- Supporting the training and education of maternity staff, in partnership with Health Education England

Further transformation to be planned in this area:

- Over the next two years
  - Implementation of safety improvements set out in the Single Delivery Plan published in March 2023
  - Implementation of Midwifery Continuity Care
- Over years three to five
  - Development of the single digital system across NEL for maternity care records

Programme funding:

- Multiple external sources, including regional maternity transformation programme funding, neonatal ODN transformation funding, plus various streams of NHS NEL funding

Leadership and governance arrangements:

- Programme leads and SROs
- Internal NHS NEL reporting
- APC governance, including APC executive and relevant oversight group

Key delivery risks currently being mitigated:

- Recruitment and retention of maternity workforce
- Stability and sustainability of programme delivery teams
- Funding to support acute demand and capacity analysis

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health		Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions		Employment and workforce		Prevention	X	Co-production	X	Learning system	

Babies, children, and young people

The benefits that north east London residents will experience by April 2024 and April 2026:

- April 2024:
  - Enhanced access to, and experience of, mental health services for children and young people
  - Setting up acute paediatric care to a range of patients and families in the community and Hosptial@Home (H@H)
  - Social prescribing and key worker offers to support early help and system navigation
  - Children aged 5 to 11 that are an unhealthy weight will have access to childrens weight management services.
- April 2026:
  - Reduction in waiting times for community-based care CYP services (less than 52 weeks)
  - Integrated family support services from pre birth through to early adulthood in their locality
  - Community-based care services are high quality and personalised (Outcomes framework)

How this transformation programme reduces inequalities between north east London's residents and communities:

- By ensuring services meet their specific needs far more closely through a whole family, personalised approach.
- By addressing inequalities of access to services by working with our seldom heard communities to improve the offer and make services more accessible, acceptable and effective.
- CYP with emotional health and wellbeing needs receive early help to maintain school engagement, pre- diagnosis support based on need, with fewer CYP requiring unplanned admissions.
- Embedding of SEND joint commissioning across education, health and care means there is equal access to high quality provision. Robust needs assessment, demand and capacity planning, workforce innovation, co-production with CYP and families, our offer will respond to the needs of our communities; with a focus on access for specific groups such as those attending independent schools. Safeguarding at Place supports our focus on reducing inequalities for our Looked After Children
- By addressing inequalities that are causing higher obesity levels in children and young people from certain backgrounds more than others, using a targeted approach where required

Key programme features and milestones:

- Improved SEND provision focuses on: leading SEND, early identification and assessment, commissioning effective services, good quality education provision & supporting successful transitions.
- Tackling childhood obesity has 3 focus areas: healthy places, healthy settings, healthy services.
- More integrated services plans to start with the ambition of creating an effective Early Help Eco system with a common practice approach
- Levelling up H@H ensuring equity of access and services
- Build upon and increase existing 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
- Developing integrated care models and pathways for children across primary secondary and community care
- Give patients and (with patient consent) carers and clinicians involved in their care, better access to their care record

Further transformation to be planned in this area:

Over the next two years to five years

- MDTs in primary care for CYP
- Expand the childrens weight management service to be located across broader footprints
- Increasing MDT working and integrated service configuration at neighbourhood level
- Further needs assessment and targeting of 0-5 services to ensure vulnerable groups access effective services earlier and don't escalate.
- Identify further collaboration opportunities between education, health and social care to ensure school readiness for all children and to meet the needs of children with SEND, autism and complex medical issues

Programme funding:

- See reference pack for details
- SDF funding
- Pooled resources
- Health inequality funding
- NHSE funding

Leadership and governance arrangements:

- NEL BCYP Executive Board & CBC
- NEL BCYP Delivery Group
- NEL ICB BCYP Delivery Leads
- NEL ICS Place based partnership boards and local governance arrangements

Key delivery risks currently being mitigated:

- Staff recruitment challenges across specific services and recognition of urgent risks across NEL
- LA pressures including SEND system and high cost packages of care (SEND estates strategy and developing joint funding arrangements in train)
- BCYP weight management service - Lack of engagement from families with children that are an unhealthy weight
- Ability to invest long term in areas that will reduce inequality whilst still trying to meet acute demand

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	X	High-trust environment	
Long-term conditions		Employment and workforce	x	Prevention		Co-production	x	Learning system	

Long-term conditions

The benefits that north east London residents will experience by April 2024 and April 2026:

April 2024:X

- By 2024 all eligible residents across NEL will have equitable access to Cardiac Rehabilitation services and a plan to further improve access to heart failure services
- Prevention of Type 2 (T2) diabetes through an increased number of people referred and starting the National Diabetes Prevention Programme (45% of eligible populations) and increase the numbers of residents who achieve T2 diabetes remission,
- Increased personalised care plans through population Health Management and coproduction
- 90% of people presenting with symptoms of Transient Ischaemic Attack will have access 7 days a week to stroke professionals who can provide specialist assessment and treatment within 24 hours of symptom onset
- 10% of eligible stroke admissions will have consistent 24/7 access to mechanical thrombectomy to reduce the impact of stroke
- All residents who experience a neurological condition will have equitable access to rehabilitation across the pathway of care (acute, bedded and community)
- Improved access to specialist Chronic Kidney Disease (CKD) intervention clinics for all NEL residents. By **2024 virtual CKD Clinics** will be available across NEL
- Early & Accurate Diagnosis of Respiratory Conditions through Primary Care Hublets (available in all 7 Places).

April 2026:

- Improve detection of **atrial fibrillation (b**y 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation) AND **hypertension** (by 2029 80% of expected numbers with hypertension are detected and 80% of people with high blood pressure are treated to target)
- Robust transition pathways for children living with diabetes across NEL
- All residents with a neurological condition will have access to the full range of specialist rehabilitation closer to home to maximise individual potential and reduce complications
- Maximise patient dialysing at home AND patients being transplanted
- Pulmonary Rehab available to patients with all chronic lung conditions and all local languages

How this transformation programme reduces inequalities between north east London's residents and communities:

- By taking a population health approach and using insights and data to inform priorities, target inequalities and variation
- By utilising deep dive data analysis into local participation rates to support target local campaigns to improve equitable access to diabetes treatment by sex
- By reducing unwarranted variation in access to specialist assessment and treatment for Neurosciences within 24 hours of symptom onset for NEL residents with TIA which currently ranges between 40% for BHR residents to 92% for City and Hackney residents
- Through the development of the home-away-from-home haemodialysis unit at Mile End Hospital and Mosque Dialysis Unit – this will give access to home haemodialysis to those who do not live in suitable properties.
- By April 2024 all Places will have accredited providers (Hublets) of Diagnostic Spirometry and FeNO to reduce inequalities across NEL (currently available in 3 Places with none-to-little provision in remaining 4 Places) to be followed by educational videos in all local languages to explain the why & how of respiratory diagnostic testing.

Key programme features and milestones:

- Roll out of the LTC outcomes framework (Q2 23/24) (led contractually by primary care) – impacting on benefits
- Co-produce 7 day TIA service with residents so that 90% of people with TIA
- *Acute care* – implement consistent 24/7 mechanical thrombectomy service by July 2023
- Dialysis & Home Therapies: Establishment of 2 home-from-home haemodialysis stations in the East London Mosque (Q3 23/24)
- Dialysis & Home Therapies: Independent Therapies Centre (ITC) at Mile End Hospital (building complete Q3 23/24)
- New Digital PR DHI with shared-working between places (co-production start. March 2023 with potential capacity for c.250 extra participants a year).
- Acute Respiratory Infection (ARI) Virtual Wards (with plan for provision in each Place before Winter 23/24).

Further transformation to be planned in this area:

Over the next two years

- Improve acute stroke standards and flow across the stroke pathway

Over years three to five

- Diabetes education platform
- Rehabilitation facilities for people with complex cognitive and behavioural challenges and disorders of consciousness

Programme funding:

- See reference pack for details
- SDF funding
- IHIP funding
- Pooled resources
- Health inequality funding
- NHSE funding

Leadership and governance arrangements:

- Pan London Networks
- NEL LTC Clinical Networks / Boards
- NEL ICB LTC Delivery Leads
- NEL ICS Place based partnership boards and local governance arrangements

Key delivery risks currently being mitigated:

- Failure to formalise joint working agreements between partners, teams and functions effecting delivery affecting delivery of NEL wide plans to address regional, national and local ambitions.
- Financial reduction in NHS SDF funding in 23.24 effecting sustainability of programmes across LTCs
- Workforce availability to staff new clinical teams and staff programme team

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	X	High-trust environment	x
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Mental health

The benefits that north east London residents will experience by April 2024 and April 2026:

April 2024:
- Increased provision of group therapies 29% of people with common mental health conditions accessing talking therapies
- 1000 patients with SMIs accessing Patient Knows Best across NEL
- 300 additional personal health budgets for people with SMI
- Roll-out of Intensive Community CAMHS Services (ICCS) across INEL
- 95% of referrals to eating disorder services seen within 1 week (urgent) or 4 weeks (routine)
- 2000 co-produced digital personalised mental health care plans
- More paid employment opportunities for people with mental health needs, including people participation as a route into paid employment

April 2026:
- 30% of people with common mental health conditions accessing talking therapies
- 2000 patients with SMIs accessing Patient Knows Best across NEL
- NHS 111 press 2 for mental health available across all places in North East London
- Talking therapies for anxiety and depression expanded to include 16 and 17 year olds
- 3000 co-produced digital personalised mental health care plans

How this transformation programme reduces inequalities between north east London's residents and communities:
- Increased availability of peer support workers, promoting access for underserved communities, and expanding our workforce so that is more representative of the communities we serve
- Through our improvement network approach, we are harnessing clinical and service user leadership, and using quality improvement and population health management tools to understand and address inequities in outcomes and experience for people with intersecting protected characteristics
- Our IAPT Improvement Network will also have a specific lens on health inequalities, and will be hosting a Population Health Fellow to help us to systematically understand which groups (e.g. people with LTCs, older adults, black men) are underserved by talking therapy services, and using QI tools and techniques to improve access, experience and outcomes for those groups
- The emphasis on targeting high-risk service users (people with SMI who are infrequent users of primary care and/or have never received a health check) through new culturally sensitive community outreach services will address health inequities driven through structural inequalities, particularly for minoritised communities across NEL
- Working to address the over-representation of black men being detained for mental health treatment through better join-up with the voluntary & community sector, and focusing on prevention

Key programme features and milestones:
- Operate a coproduction of place between partner and residents with lived experience to develop and deliver resident centred services
- Additional crises bed capacity brought online and operational by October 2023 (in preparation for winter)
- First roll-out of NHS 111 press 2 for mental health by end of March 2024 (may be staggered by geography)
- Coproduction event planned for April 2023 to support the development of Lived Experience Leaders in CYP
- Expansion of talking therapies to 16/17s by March 2025

Further transformation to be planned in this area:

Over the next two years
- Review and potential expansion of MH joint response cars
- Social prescribing plan for CYPs developed in line with iThrive principles with service users

Over years three to five
- Comprehensive digital offer underpinning NEL mental health and emotional wellbeing approach
- Lived Experience-Led crisis service developed

Programme funding:
- See reference pack for details
- SDF and MHIS funding
- Investment and innovation fund
- Pooled resources
- NHSE funding

Leadership and governance arrangements:
- MHLDA Collaborative Committee
- Programme Boards
- IAPT Improvement, crisis Improvement, CYP Mental Health Improvement Networks
- NEL ICS Place-based partnership boards and local governance arrangements

Key delivery risks currently being mitigated:
- In some boroughs reduced access has been caused by high numbers of staff vacancies. Through focused efforts to increase recruitment and retention, and work across the Improvement Network to harness mutual support, these are largely mitigated for 2023/24
- There are issues with the integration engine to enable bi-directional data flows between trust records and Patient Knows Best. However, work is currently underway with digital leads to resolve this.
- Programmes sits in multiple portfolios (e.g. primary care, frailty, mental health, end of life, planned care, social care) which means that there is a lack of clarity across places and the system on leadership and improvement goals. This risk could be mitigated through the resourcing and establishment of a NEL wide-programme, led by the MHLDA Collaborative, with strong links into place-based partnerships and other provider collaboratives and ICS workstreams
- There is currently a full-time programme manager supporting this work, funded by the ICB non-recurrently. There is no clarity on longer term resource available.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Employment and workforce

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - We will deliver by April 2025 900 jobs in health and care to residents in NEL
  - All providers to agree to work towards gaining accreditation for London Living Wage
  - We will work with partners to develop roles and services that provide services out of hospital
- April 2026: To be confirmed
  - Establish a permanent hub for local population to access job opportunities in health and care (To be confirmed)
  - Methodology for planning and introducing new roles building on the learning from collaboratives and development of new services and approaches (St Georges)

How this transformation programme reduces inequalities between north east London's residents and communities:

- By providing employment opportunities to our local residents in our health and care organisations providing employment to ensure social mobility.
- By ensuring opportunity and development to our residents to reduce deprivation and health opportunities
- By providing career pathways for our staff to develop skills that deliver effective health and care to our
- By ensuring that all employers agree to commit and start accreditation to be a london Living Wage employer

Key programme features and milestones:

- June 2023 Recruitment Health Hub and Social Care Hub to be operational
- April 2024 900 starts in London Living Wage posts across employers in Health and Care
- April 2024 – Learning from Bank and agency and good practice examples highlighted, shared and adopted
- April 2024 - System-wide integrated high-level co-designed Workforce Strategy focusing on enabling system-wide workforce transformation at System, Place and Neighbourhood, to be signed off.
- April 2024 – Workforce Productivity activities to contribute to deliver of activity and finance requirements 2from 2022-23 operational plan

Further transformation to be planned in this area:

- Over the next two years
  - Develop five-year co-designed NEL ICS workforce strategy action plan to deliver objectives, priorities and programmes
  - Shared workforce across health, technology starting with acute collaboratives, Care using collaboratives
  - Increase substantive posts within providers to reduce reliance on bank and agency and productivity
  - Build on Health and Care hubs to explore feasibility of training academies to support pipeline
- Over years three to five: TBC

Programme funding:

- Non recurrent, Funding from NHSE/Health Education England and GLA where fit against NEL priorities
- Funding redistribution as we move to new models of community care

Leadership and governance arrangements:

- To be confirmed SRO for specific areas of transformation
- NEL People Board, EMT and the ICB Executive

Key delivery risks currently being mitigated:

- No confirmed and recurrent funding to support workforce transformation and innovation
- No funding clarity for ARRs roles for in Primary Care
- Turnover rate increases due to ageing work population
- Burnout of health and care staff caused by increased workload and pandemic
- Mitigations Turnover and Burnout: Creation of a single NEL workforce offer including health and wellbeing, development and mobility

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce	X	Prevention		Co-production		Learning system	X

Physical infrastructure

The benefits that north east London residents will experience by April 2024 and April 2026:

- Across NEL ICS organisations, there are 332 estates projects in our pipeline over the next 5 /10 years, with a total value of c. £2.9 billion
- These include the redevelopment of Whipps Cross hospital and a new site at St Georges
- Formal opening of new St Georges Hospital Site – **Spring 2024**

How this transformation programme reduces inequalities between north east London's residents and communities:

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:										
	Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care		High-trust environment	
	Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production		Learning system	

Digital infrastructure

The benefits that north east London residents will experience by April 2024 and April 2026:

- Improve accuracy of record keeping and recall within the trust, enabling patients to 'tell their story once', enable efficient handovers and staff communication
- Online registration for GP patients
- Rollout of the call/recall Active Patient Link tools for Childhood Immunisation and Atrial Fibrillation
- Delivery of the patient held record programme to improve communication channels with patients and reduce unnecessary visits to hospital (Patient Initiated Follow Up)

How this transformation programme reduces inequalities between north east London's residents and communities:

- Developing a linked dataset to support the identification of specific populations (utilising CORE25 plus 5 methodology) to target and organise health and care interventions to improve outcomes, drive self care and reduce inequalities
- Improve the availability, timeliness and quality of clinical data
- Support clinical decision making by reducing the need to check other systems for information

Key programme features and milestones:

- Single provider for acute EPRs (replacing BHRUT's)
- Single provider for General Practice patient record systems
- East London Patient Record (eLPR) Shared care record across all providers – to be expanded to include social care, pharmacists, care homes, community providers and independent providers
- Promotion of the NHSApp as the 'front door' to NHS services, including Patient Knows Best (PKB), primary care record, Online Consultations and ordering of repeat prescriptions
- Maternity service digitisation Expanding the Electronic Prescription Service to outpatient services

Further transformation to be planned in this area:

- move to cloud based telephony across primary care to facilitate collaboration across practices and PCNs
- Implementation of shared digital image capture and real-time sharing to reduce unnecessary procedures after transfers
- Network, cyber and end user device improvements (using VDI where practical) to improve staff experience and ease of access to information

Programme funding:

- £220m capital, £270m revenue over 5 years; including £43m for EPR replacement for BHRUT and £2.7m investment in care home EPRs.

Leadership and governance arrangements:

- Programmes have their own Boards reflecting footprint of decision-making (OneLondon is London wide; Digital; First is NEL). All report through IG Steering Group, Data Access Group and Clinical Advisory Group

Key delivery risks currently being mitigated:

- Risk that insufficient capital is available to fund all programmes. Options for staggering programmes being developed

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production		Learning system	X

Further programmes

Across our partnership there are many further programmes, beyond those described in the previous section, that are focused on specific populations or responding to specific local priorities. More detail on these programmes can be found in the reference pack accompanying this plan. Below is a snapshot of those programmes, along with where ownership for them sits within the system.

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Led by	Programme	Page*
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6. Implications and next steps

Early lessons from work to develop this plan

- The previous section is a significant step towards the collaborative and co-ordinated management of north east London's transformation portfolio.
- The portfolio demonstrates the **ambition**, **energy**, and **creativity** of north east London's health and care partners.
- At this stage, however, it is a relatively raw write-up of current transformation by teams across north east London leading the programmes, with further work needed during the engagement phase on articulating the full detail for each programme and further understanding of the overlaps between programmes and gaps within them
- Initial **learning** from the work to bring together these currently disparate programmes is that we need to:
  - better understand and explain the specific beneficial impact of each programme for residents by key dates, as the basis for ongoing investment in the programmes;
  - reframe our programmes around the needs of our local people rather than the services we provide;
  - understand the affordability of these programme plans as they are predicated on current finance and people resources, which are coming under increasing pressure;
  - ensure full alignment between multiple programmes across a common theme to ensure that delivery is integrated and efficient;
  - progress in some areas from restating strategy to setting out plans with clear timelines and deliverables; and
  - develop a medium-term view of how individual programmes progress, or whether they should be assumed to finish and close after current plans have been delivered.
- These areas will all be worked as we iterate the plans and programmes described between now and June 2023.

Analysing our transformation portfolio - i

- The table below shows, at a headline level, how the programmes within the current system portfolio align to:
  - the integrated care strategy – both flagship priorities and cross-cutting themes; and
  - the requirements of the operating plan.
- Alignment with the integrated care strategy has been identified by the programme teams and alignment to the operating plan has been added by the portfolio management office.
- This is a currently retrofitted view, given that the portfolio has developed organically rather than in response to strategy or the broad areas in this year's operating plan requirements.

	Area	Programme	Lead system partner	Babies, children, and young people	Long-term conditions	Mental health	Employment and workforce	Tackling heath inequalities	Prevention	Personalisation	Co-production	High-trust environment	A learning system	Urgent and emergency care	Community health services	Primary care	Elective care	Cancer	Diagnostics	Maternity	Use of resources	Workforce	Mental health	People with a learning disability and autistic people	Prevention and health inequalities	**How are does the programme have a five-year forward view?** (R: absence; A: broad intentions; G: full set of milestones) As set out in the benefits and further planned transformation boxes
Recovering our core services and improving productivity	**Urgent and emergency care**	Urgent and emergency care	Acute provider collaborative				X				X			X	X											Red
		Enhanced health in care homes	Community collaborative	X	X		X	X		X	X	X	X	X		X										Amber
		Ageing Well (focus on urgent community response)		X	X	X	X	X	X	X	X	X	X	X								X				Amber
	Community helath services	Digital community services	Community collaborative	X	X	X	X	X	X	X	X	X	X	X	X	X	X					X			X	Amber
		End-of-life care		X	X		X	X	X	X	X	X	X													Amber
		Post-covid care		X	X	X	X	X			X	X	X	X	X	X			X			X				Amber
		Proactive care / Anticipatory care			X		X	X	X	X	X	X														Amber
		Virtual wards			X		X	X		X	X	X	X	X	X											Amber
	Primary Care	Digital First	Primary care collaborative	X			X	X	X	X	X	X	X			X						X			X	Amber
		Same-day access		X	X	X	X	X	X		X	X		X		X					X	X				Red
		Tackling unwarranted variation, levelling up, and addressing inequalities														X					X	X			X	Amber
	Planned care and diagnositcs	Planned care	Acute provider collaborative		X			X							X	X	X		X							Red
	Cancer	Cancer	Acute provider collaborative		X													X								Red
	Materity	Maternity	Acute provider collaborative	X				X			X															Red
		Maternity	NHS NEL												X					X		X	X		X	Amber
		Maternity safety and quality assurance programme	NHS NEL												X					X		X	X		X	Red

Analysing our transformation portfolio - ii

	Area	Programme	Lead system partner	Babies, children, and young people	Long-term conditions	Mental health	Employment and workforce	Tackling heath inequalities	Prevention	Personalisation	Co-production	High-trust environment	A learning system	Urgent and emergency care	Community health services	Primary care	Elective care	Cancer	Diagnostics	Maternity	Use of resources	Workforce	Mental health	People with a learning disability and autistic people	Prevention and health inequalities	How are does the programme have a five-year forward view? (R: absence; A: broad intentions; G: full set of milestones) As set out in the benefits and further planned transformation boxes
ICS flagship priorities	**Babies, children and young people** – to make north east London the best place to grow up, through early support when it is needed and the delivery of accessible and responsive services	Developing clearly defined prevention priorities for BCYP	NHS NEL	X		X		X	X		X	X			X	X										Red
		Community-based care	NHS NEL											X	X	X										Amber
		Vulnerable babies, children and young people	NHS NEL											X	X								X	X	X	Amber
		Babies, children and young people	Acute provider collaborative	X							X															Red
		Babies, children and young people	Community collaborative	X	X	X	X	X	X	X	X	X	X	X	X										X	Amber
		Best chance for babies, children, and young people	Barking and Dagenham place partnership	X	X	X		X	X	X	X		X		X	X				X					X	Amber
		Children, young people, maternity, and families	City and Hackney place partnership	X	X	X	X	X	X	X	X	X	X		X									X		Amber
		Childhood immunisations	City and Hackney place partnership	X				X	X	X	X														X	Amber
		Starting well	Havering place partnership	X	X			X	X																X	Amber
		Born well, grow well	Tower Hamlet place partnership	X	X	X		X	X	X	X	X	X										X		X	Red
		Babies, children, and young people	Waltham Forest place partnership	X	X	X	X	X	X		X		X	X		X									X	Amber
	Long-term conditions – to support everyone living with a long-term condition in north east London to live a longer, healthier life and to work to prevent conditions occurring for other members of our community	CVD	NHS NEL	X	X	X	X	X	X	X	X	X	X		X	X				X			X			Amber
		Diabetes	NHS NEL	X		X	X	X	X	X	X			X	X	X							X			Amber
		Neurosciences	NHS NEL		X			X	X	X	X			X											X	Amber
		Renal	NHS NEL	X	X	X	X	X	X	X	X	X	X	X	X	X					X				X	Red
		Respiratory	NHS NEL		X	X	X	X	X	X	X	X		X	X	X			X			X			X	Amber
		Prevention / Prohab	Barking and Dagenham, Havering and Redbridge Places	X	X	X	X	X	X	X	X	X	X	X	X	X			X		X	X			X	Amber
		Cardiology	Barking and Dagenham, Havering and Redbridge Places		X	X	X	X	X	X	X	X	X	X	X	X			X			X			X	Amber
		Diabetes	Barking and Dagenham, Havering and Redbridge Places	X	X	X	X	X	X		X		X	X	X	X						X			X	Amber
		Improving outcomes for people with long-term health and care needs	City and Hackney place partnership		X			X	X	X	X								X							Amber
		Enhanced community response	City and Hackney place partnership		X	X	X	X	X		X			X	X							X	X		X	Amber
		Cardiovascular Disease Prevention	Redbridge place partnership	X	X	X	X	X	X	X	X	X	X	X	X	X			X		X	X	X		X	Amber
	Mental health – to transform accessibility to, experience of and outcomes from mental health services and well-being support for the people of north east London	Perinatal mental health improvement network	Mental health, learning disabilities, and autism collaborative	X		X		X	X		X	X	X		X					X		X	X		X	Amber
		IAPT improvement network			X	X		X	X		X	X	X										X		X	Red
		Improving health outcomes and choice for people with severe mental illness			X	X		X	X	X	X	X	X	X									X		X	Amber
		Improving outcomes and experience for people with dementia and their carers			X	X		X	X	X	X	X	X										X		X	Amber
		Crisis improvement network		X		X		X	X		X	X	X	X	X	X						X			X	Amber
		Children and young people's mental health improvement network		X		X	X	X	X	X	X	X	X		X	X						X	X		X	Amber
		Mental Health	City and Hackney place partnership		X	X		X	X	X	X												X	X	X	Amber
		Mental Health	Havering place partnership			X	X	X	X					X	X	X			X				X		X	Amber
		Mental health	Tower Hamlets place partnership	X	X	X	X	X	X	X	X	X	X									X	X	X		Red
		Mental Health	Waltham Forest place partnership			X	X	X	X					X		X							X			Red
	Employment and workforce – to work together to create meaningful work opportunities and employment for people in north east London now and in the future	Workforce transformation	NHS NEL	X	X	X		X	X	X	X	X		X	X	X						X				Amber
	Infastructure	Digital Infastrucutre	NHS NEL																							
		Physical infastrcuture	NHS NEL																							

Analysing our transformation portfolio - iii

	Area	Programme	Lead system partner	Babies, children, and young people	Long-term conditions	Mental health	Employment and workforce	Tackling heath inequalities	Prevention	Personalisation	Co-production	High-trust environment	A learning system	Urgent and emergency care	Community health services	Primary care	Elective care	Cancer	Diagnostics	Maternity	Use of resources	Workforce	Mental health	People with a learning disability and autistic people	Prevention and health inequalities	How are does the programme have a five-year forward view? (R: absence; A: broad intentions; G: full set of milestones) As set out in the benefits and further planned transformation boxes
Additional work led by provider collaboratives	**Acute provoider collaborative**	Critical care	Acute provider collaborative								X			X												Red
		Research and clinical trials	Acute provider collaborative								X		X													Red
		Specialist services	Acute provider collaborative		X				X		X			X	X											Red
	Mental health, learning disabilities, and autism collaborative	Learning disabilities and autism improvement programme	Mental health, learning disabilities, and autism collaborative	X	X	X		X		X	X	X	X	X	X	X								X		Amber
		Lived experience leadership programme		X		X	X	X			X	X	X		X								X		X	Amber
Additional work led by place partnerships	**Barking and Dagenham**	Ageing well	Barking and Dagenham place partnership		X	X		X	X	X		X	X	X	X	X							X			Amber
		Healthier weight		X	X			X	X						X	X										Amber
		Stop smoking		X	X	X		X	X	X					X	X									X	Amber
		Estates		X	X	X	X	X	X	X	X					X			X						X	Amber
	City and Hackney	Supporting residents with cost of living pressures	City and Hackney place partnership	X	X	X	X	X	X					X		X										X	Amber
		Population health		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Red
		Neighbourhoods programme			X	X	X	X	X		X	X	X		X	X										X	Amber
	Havering	Infrastructure and enablers	Havering place partnership	X	X	X		X	X	X	X	X											X	X		Amber
		Building community resilience		X	X	X	X	X	X	X	X	X	X												X	Amber
		St George's health and wellbeing hub		X	X	X	X	X	X	X	X	X	X		X	X			X		X	X	X	X	X	Amber
		Living well		X	X	X	X	X	X	X	X				X	X							X		X	Amber
		Ageing Well			X				X	X				X	X	X									X	Amber
	Newham	Frailty model	Newham place partnership		X	X		X	X	X				X		X							X		X	Amber
		Neighbourhood model		X	X	X	X	X	X	X	X	X	X		X	X											Amber
		Population growth		X	X	X	X	X	X	X	X	X	X		X	X							X				Red
	Redbridge	Health inequalities	Redbridge place partnership	X	X	X	X	X	X	X	X	X	X	X	X	X			X		X	X		X	X	Red
		Accelerator priorities		X	X	X	X	X	X	X	X	X	X	X	X	X			X		X	X	X		X	Amber
		Development of Ilford Exchange Health and Care Centre		X	X	X	X	X	X	X	X	X	X		X	X					X	X			X	Amber
	Tower Hamlets	Living well	Tower Hamlets place partnership		X			X	X		X	X	X			X			X						X	Red
		Promoting independence			X	X		X	X	X	X	X	X		X											Red
	Waltham Forest	Centre of Excellence	Waltham Forest place partnership		X	X	X	X	X	X	X	X	X	X	X	X					X	X			X	Red
		Care closer to home			X	X	X	X	X	X	X	X	X	X	X	X							X			Amber
		Home first			X	X	X	X	X	X	X	X	X	X	X	X						X				Amber
		Learning disabilities and autism																					X	X	X	Red
		Wellbeing					X	X	X	X	X	X	X	X	X							X			X	Red
Additional work led by NHS NEL on behalf of the system	**Prevention and health inequalities**	Tobacco dependence treatment programme	NHS NEL	X	X	X		X	X	X	X	X	X	X			X	X		X					X	Amber
		NEL homelessness programme			X	X	X	X	X	X	X	X	X	X	X	X							X		X	Amber
		Anchors programme				X	X	X	X	X	X	X	X													Amber
		Net zero (ICS Green Plan)		X	X	X	X	X	X	X	X	X	X													Amber
		NEL refugees and asylum seeker working group		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Amber
	Unplanned care	Discharge pathways programme												X		X										Amber

Next steps

Summary engagement plan for April-June to be added to final NHSE submission

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

Technical work

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

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

Engagement

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

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

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7. National planning requirements lookup tables

Links to other plans and strategies

NHSE guidance described a number of areas Joint Forward Plans should cover, many of which are covered within existing plans and strategies (held and/or developed by various partners across the system) or those under development. Rather than duplicate those plans within the JFP we have referenced them below

Additional plan requirements	
Requirement	Strategies and plans already developed
Describing the health services for which the ICB proposes to make arrangements	Integrated care strategy; all delivery plans set out in the reference document; operating plan
Duty to promote integration	Integrated care strategy; Mutual accountability framework for place partnerships and provider collaboratives; ICB governance review
Duty to have regard to wider effect of decisions	Integrated care strategy; NEL Quality Approach Framework; NEL ICS Green Plan
Financial duties	NEL Financial Strategy
Implementing any JLHWS	Integrated care strategy; place-based transformation plans (see reference document)
Duty to improve quality of services	NEL Quality Approach Framework
Duty to reduce inequalities	Integrated care strategy; all transformation plans set out in the accompanying document
Duty to promote involvement of each patient	Integrated care strategy; and references to personalisation in transformation plans set out in the reference document)
Duty to involve the public	NEL Working with People and Communities Strategy
Duty to promote patient choice	ICB Governance Handbook

Additional plan requirements	
Requirement	Strategies and plans already developed
Duty to obtain appropriate advice	NHS NEL governance handbook
Duty to promote research and innovation	Barts Life Sciences; Research Engagement Network partnering with UCLP and North Thames Clinical Research Network
Duty to promote education and training	Integrated care strategy; employment and workforce transformation plan; ICS People Plan under development
Duty as to climate change, etc.	NEL ICS Green Plan
Addressing the particular needs of children and young persons	Integrated care strategy; BCYP transformation plans (see reference document)
Addressing the particular needs of victims of abuse	Place-based plans and Multi Agency Risk Assessment Conference
Procurement and supply chain	NEL Procurement Group; ‘Evaluating and embedding social values in procurement’ (ELFT); NEL Anchor Charter
Population health management	NEL PHM Roadmap
System development	Mutual accountability framework for place partnerships and provider collaboratives; ICB governance review
Supporting wider social and economic development	NEL Anchor Charter

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8. Annexes

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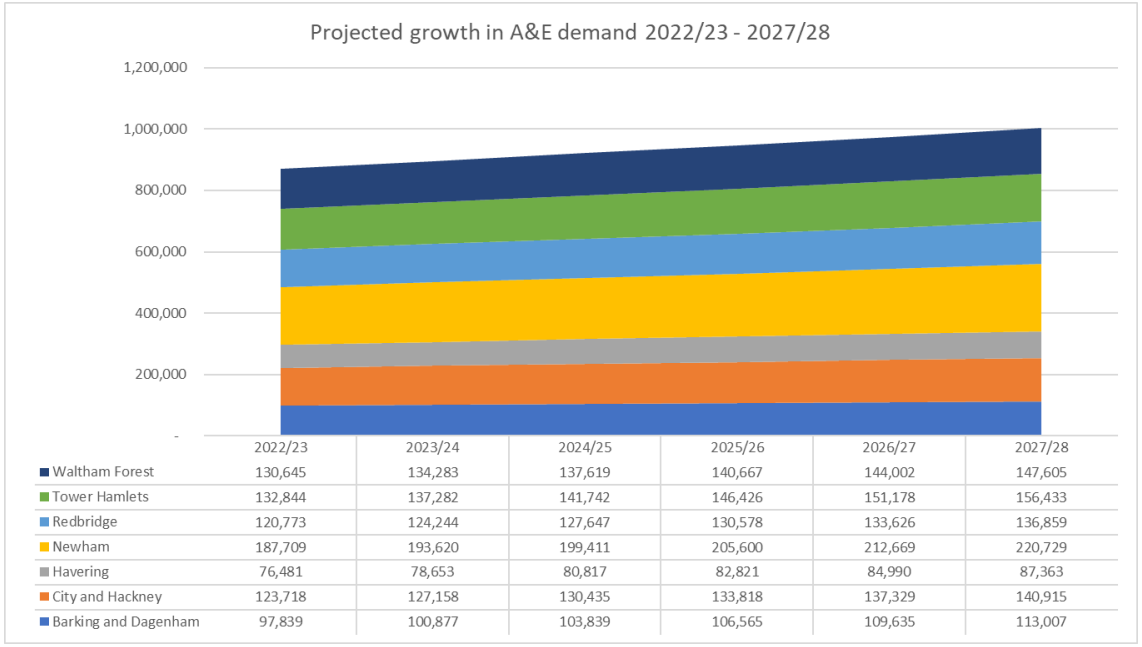
Annex A - demand projections

How we expect demand to change - projections for UEC

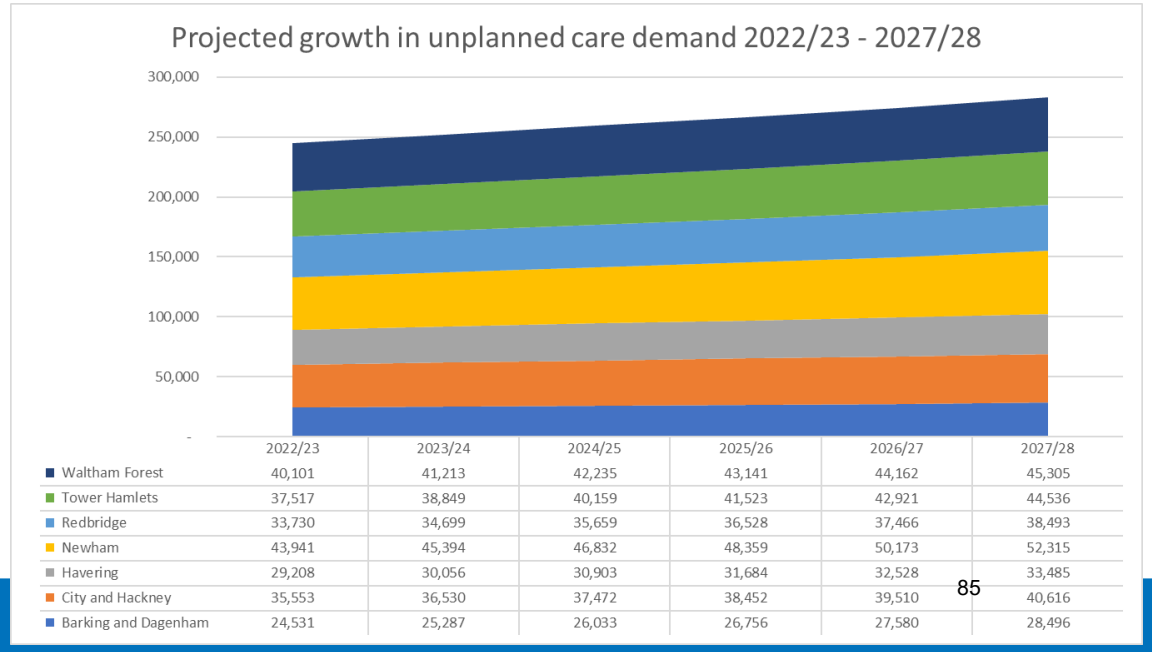
A&E demand is expected to grow – as a result of demographic and non-demographic growth – by 15.3% during the five-year period. That would equate to around 133,000 extra A&E attendances.

Unplanned care is also expected to grow – as a result of demographic and non-demographic growth – by 15.8% during the five-year period, which would equate to an extra 38,500 non-elective admissions.

Newham (19.1%) and Tower Hamlets (18.7%) are projected to see the largest increases.



	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	130,645	134,283	137,619	140,667	144,002	147,605
Tower Hamlets	132,844	137,282	141,742	146,426	151,178	156,433
Redbridge	120,773	124,244	127,647	130,578	133,626	136,859
Newham	187,709	193,620	199,411	205,600	212,669	220,729
Havering	76,481	78,653	80,817	82,821	84,990	87,363
City and Hackney	123,718	127,158	130,435	133,818	137,329	140,915
Barking and Dagenham	97,839	100,877	103,839	106,565	109,635	113,007

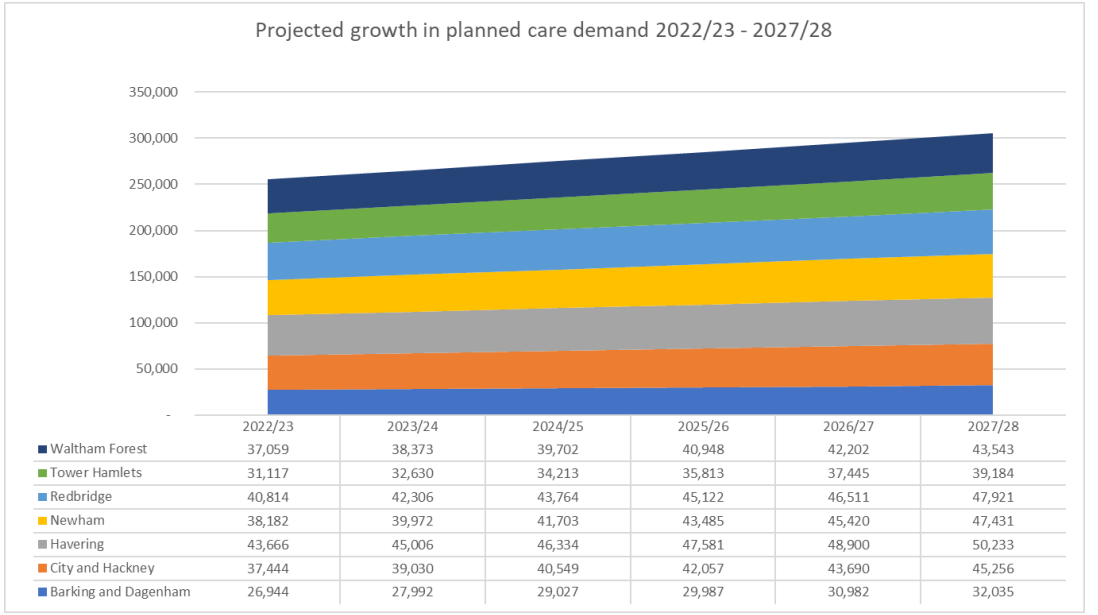


	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	40,101	41,213	42,235	43,141	44,162	45,305
Tower Hamlets	37,517	38,849	40,159	41,523	42,921	44,536
Redbridge	33,730	34,699	35,659	36,528	37,466	38,493
Newham	43,941	45,394	46,832	48,359	50,173	52,315
Havering	29,208	30,056	30,903	31,684	32,528	33,485
City and Hackney	35,553	36,530	37,472	38,452	39,510	40,616
Barking and Dagenham	24,531	25,287	26,033	26,756	27,580	28,496

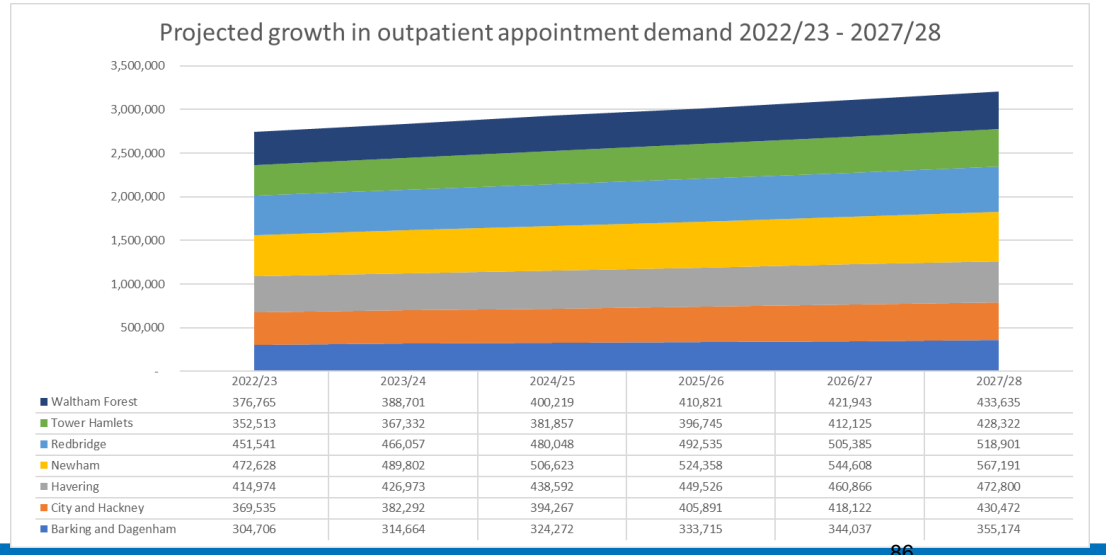
Figures are based on modelling by the NEL Insights Team which uses GLA population growth projections

Demand projections for planned care

Across north east London, demand for planned care is expected to grow by 19.7% between 2022/23 and 2027/28, or by around 4% per year.



	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	37,059	38,373	39,702	40,948	42,202	43,543
Tower Hamlets	31,117	32,630	34,213	35,813	37,445	39,184
Redbridge	40,814	42,306	43,764	45,122	46,511	47,921
Newham	38,182	39,972	41,703	43,485	45,420	47,431
Havering	43,666	45,006	46,334	47,581	48,900	50,233
City and Hackney	37,444	39,030	40,549	42,057	43,690	45,256
Barking and Dagenham	26,944	27,992	29,027	29,987	30,982	32,035



	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	376,765	388,701	400,219	410,821	421,943	433,635
Tower Hamlets	352,513	367,332	381,857	396,745	412,125	428,322
Redbridge	451,541	466,057	480,048	492,535	505,385	518,901
Newham	472,628	489,802	506,623	524,358	544,608	567,191
Havering	414,974	426,973	438,592	449,526	460,866	472,800
City and Hackney	369,535	382,292	394,267	405,891	418,122	430,472
Barking and Dagenham	304,706	314,664	324,272	333,715	344,037	355,174

Demand projections for diagnostics

Across north east London demand for imaging diagnostics is expected to grow by around 18%, or 3.6% per year

Imaging diagnostics projected demand growth 2022/23 - 2027/28

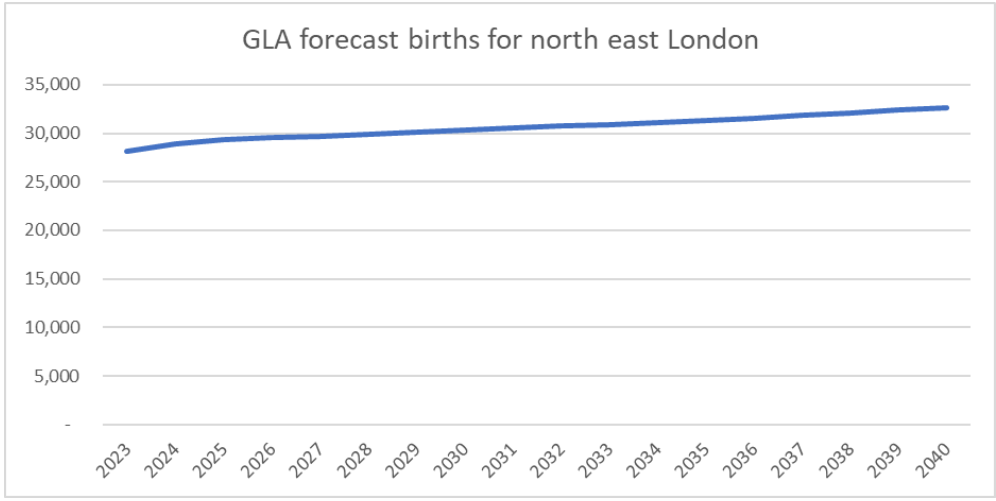
	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Growth
Cone Beam CT	1,515	1,557	1,599	1,643	1,690	1,738	**14.7%**
CT Scan	214,182	223,675	233,001	242,000	251,320	261,346	**22.0%**
Endoscopy	1,668	1,744	1,818	1,888	1,962	2,041	**22.4%**
Fluoroscopy	29,532	30,780	31,998	33,160	34,398	35,674	**20.8%**
Medical photography	14	14	15	16	16	18	**28.6%**
MRI	199,421	206,903	214,152	221,127	228,537	236,128	**18.4%**
Nuclear Medicine	17,546	18,281	18,984	19,665	20,389	21,148	**20.5%**
PET-CT Scan	6,098	6,388	6,682	6,955	7,247	7,539	**23.6%**
SPECT Scan	1,253	1,302	1,344	1,385	1,424	1,463	**16.8%**
Ultrasound	565,530	583,749	601,181	617,962	635,933	655,186	**15.9%**
X-ray	884,831	918,064	950,447	981,507	1,014,316	1,048,943	**18.5%**
All imaging	1,921,590	1,992,457	2,061,221	2,127,308	2,197,232	2,271,224	**18.2%**

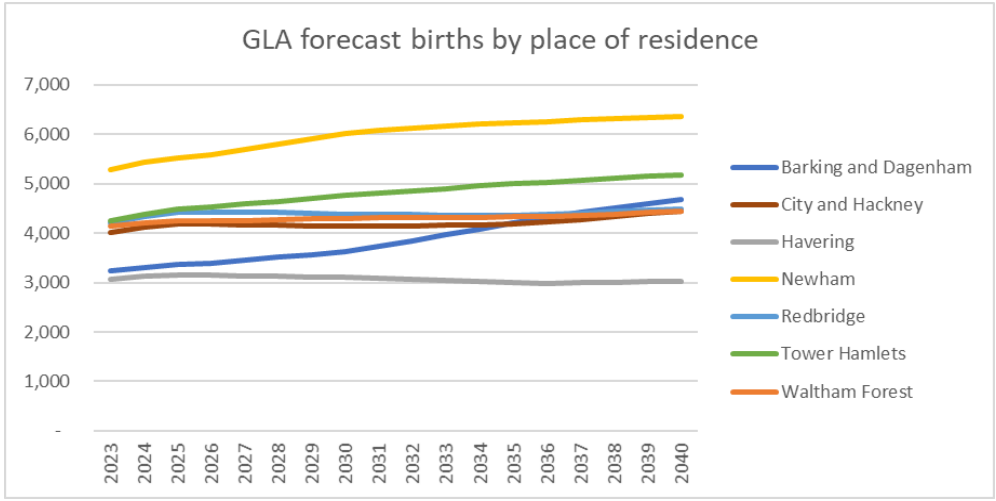
Demand projections for maternity

Total births in north east London is projected to grow by almost 16% between 2023 and 2040, or 0.9% per year

In Barking and Dagenham growth is projected to be 47% over the same period, or 2.8% per year.

Havering forecast a reducing number of births between 2026 and 2036.





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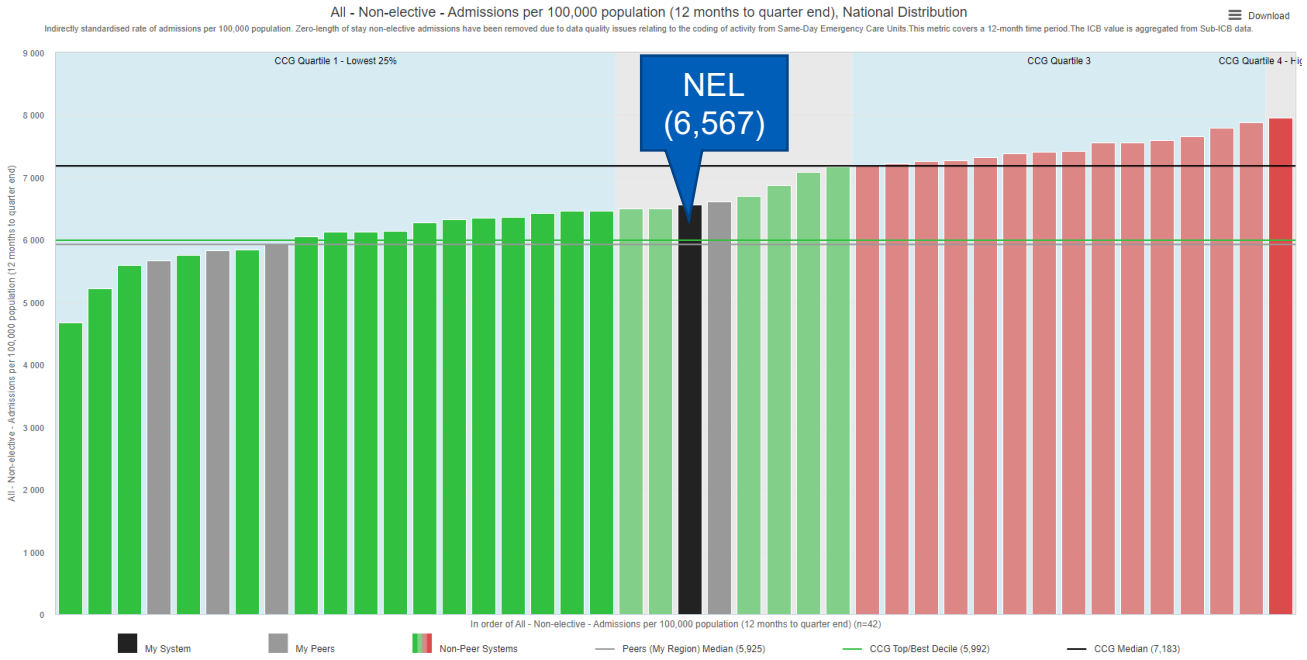
Annex B - benchmarking

Urgent and Emergency care benchmarking

Non-elective admission rates

Improving non-elective admission rates to the London median would mean 642 fewer admissions per 100,000 population, or an improvement of just under 10%

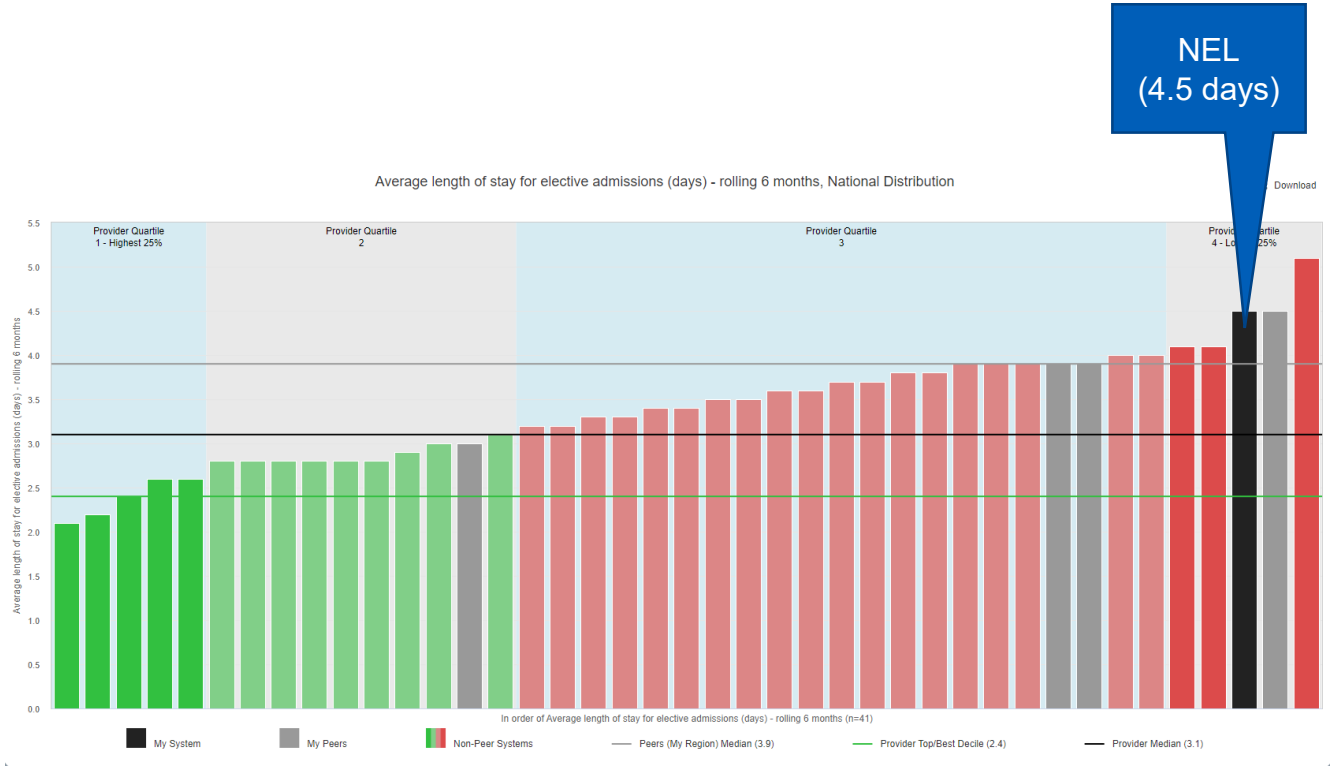


Data is from 'Model Health System' and covers a 12-month period, ending Q2 2022/23.

Elective care benchmarking

LOS for elective admissions

Improving length of stay to London median (3.9 days) would mean 13% fewer bed days. Moving to the England median would mean 31% fewer beds days.



Data is from 'Model Health System' and looks at average LOS for elective admissions, excluding day cases. It covers a 6-month period, ending Q3 2022/23.

NHS
North East London

Annex C - improvement opportunities data

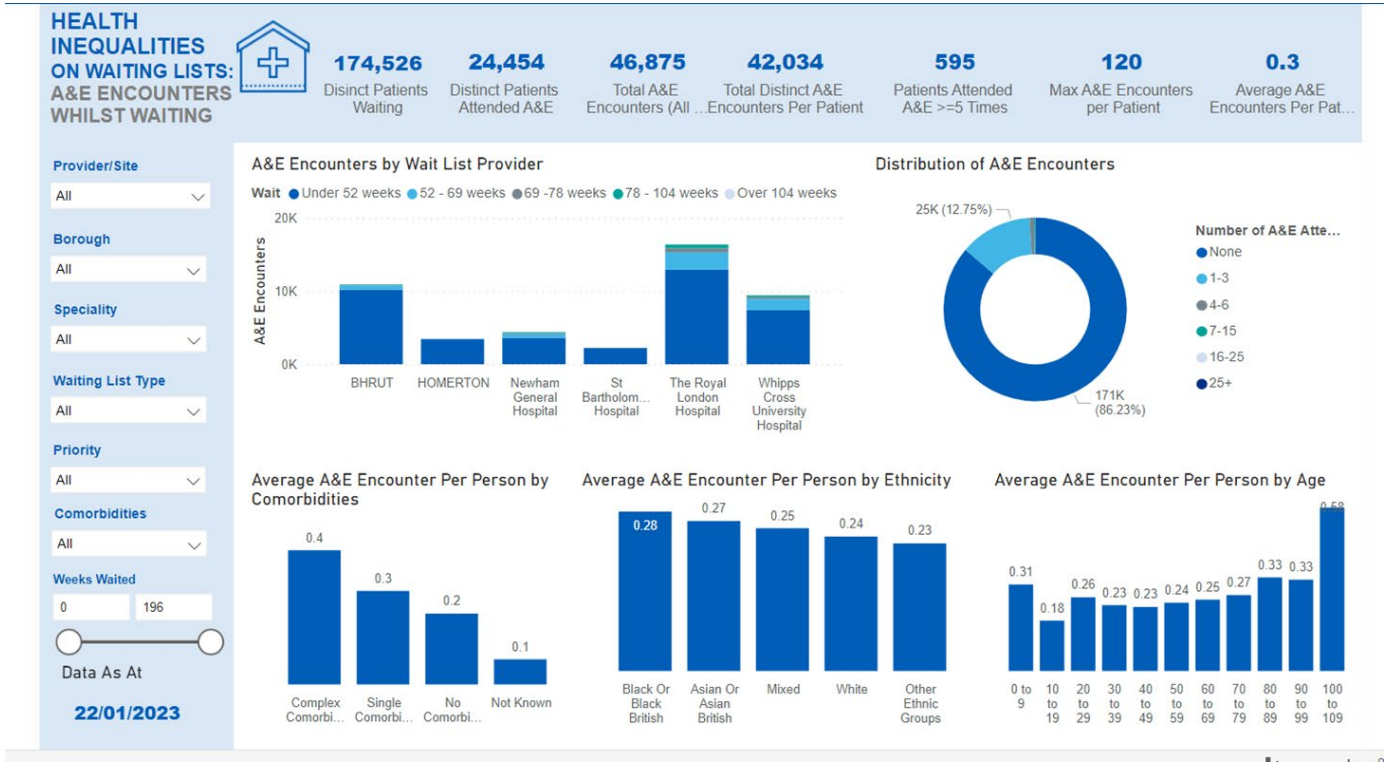
UEC – opportunities for improvement

Waiting list management

There are currently ~174,000 people waiting for elective care. Of that group around 600 have attended A&E 5 times or more while waiting.

The majority of people waiting (86%) have not attended A&E while waiting, however the remaining 14% have attended A&E almost 47,000 times while waiting.

One person waiting (for non-admitted care) has attended A&E 120 times whilst on the waiting list (they have no recorded comorbidity).



UEC – opportunities for improvement

Care home ambulance calls

There is significant variation in the quantum of incidents across our places – with more than 10 times as many incidents in Havering vs. City and Hackney (note that these figures do not adjust for the number of residents, age, complexity etc of care home residents).

Non-conveyance rates are higher everywhere except B&D than the London average.

London Ambulance Service Incidents Attended At Care Home Locations (April 22 - July 22)

Locality	Incidents	Conveyed	Non conveyed	Non conveyed %	Blue Calls	% Blue call
Barking and Dagenham	184	140	44	24%	47	26%
City and Hackney	55	37	18	33%	9	16%
Havering	597	420	177	30%	124	21%
Newham	157	102	55	35%	38	24%
Redbridge	318	218	100	31%	80	25%
Tower Hamlets	109	54	55	50%	15	14%
Waltham Forest	336	217	119	35%	74	22%
NEL Total	**1756**	**1188**	**568**	**32%**	**387**	**22%**
London average				**29%**		**21%**

UEC – opportunities for improvement

Avoidable admissions

Emergency admissions for conditions not usually requiring hospital treatment

The indicator measures the number of emergency admissions to hospital in England for acute conditions such as ear/nose/throat infections, kidney/urinary tract infections and angina, among others, that could potentially have been avoided if the patient had been better managed in primary care.

The NEL average rate of admissions for conditions not usually requiring hospital treatment is 8.8 admissions per 1,000 patient population. The rate among ten practices with highest rates is between 19.9 and 13.6.

Six of the top ten rates are from GP Practices within the Barking and Dagenham, three from Havering practices and one from City and Hackney.

Among the 273 NEL practices included as operational during the period of this analysis, 37 practices have a rate that is identified as a (statistically significant) high outlier compared to rates at all NEL practices and accounting for the underlying practice populations

Unplanned hospitalisations for chronic ambulatory care sensitive conditions

This indicator measures how many people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, diabetes, epilepsy and high blood pressure.

This outcome is concerned with how successfully NHS health services manages to reduce emergency admissions for all long-term conditions where optimum management can be achieved in the community.

The NEL average rate of unplanned hospitalisations for chronic ambulatory care sensitive conditions is admissions is 8.2 admissions per 1,000 patient population. The rate among ten practices with highest rates is between 16.4 and 13.3.

Nine of the top ten rates are from GP Practices within the Barking & Dagenham, one is from a Waltham Forest Practice.

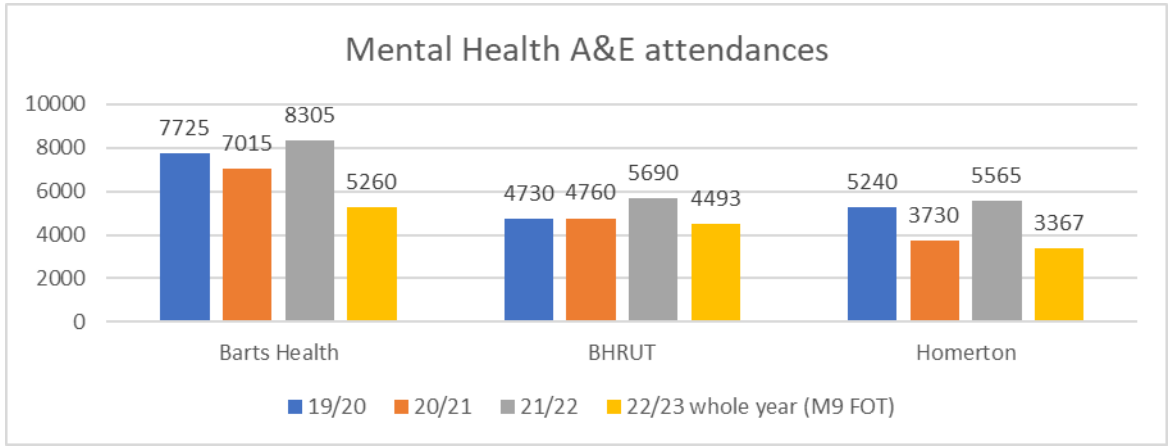
Among the 273 NEL practices included as operational during the period of this analysis, 46 practices have a rate that is identified as a (statistically significant) high outlier compared to rates at all NEL practices and accounting for the underlying practice populations

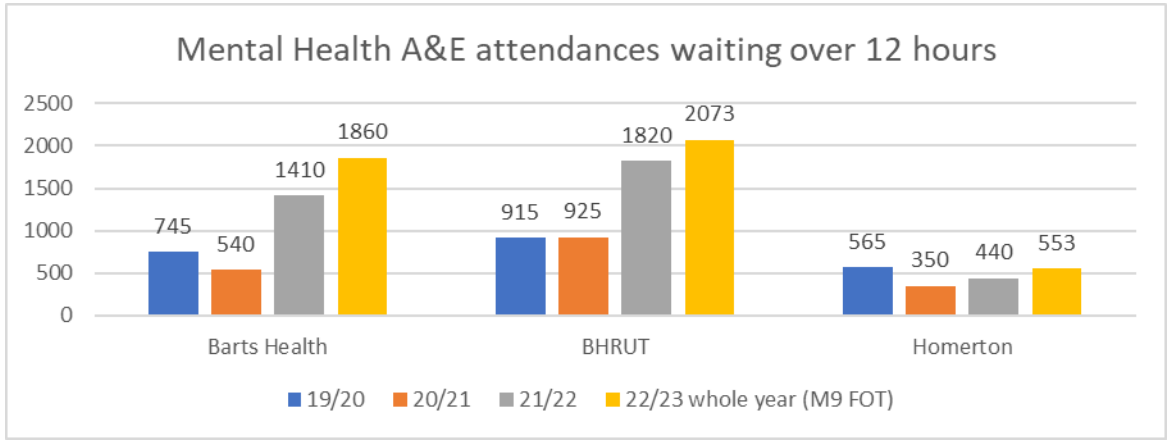
UEC – opportunities for improvement

Mental health patients in A&E

There appears to be a reduction in the number of mental health patients attending A&E across NEL, while the number waiting over 12 hours has been increasing.

During 22/23 (July-Sept) ELFT and NELFT averaged 90.9% and 89.9% overnight bed occupancy respectively.





The north east London health and care system – children's and adult social care services

The size of children's social care in East London

Children social care numbers

1st April 2021-31st March 2022

Children *during the year* | Children *at 31st March 2022*

Referrals	*Assessments*	*s47 investigations*	*Child Protection*	*Children looked after*	*Care experienced*
*35,505** (Hackney figures based on 2019/20)	33,243* (Hackney figures based on 2019/20)	9,822* (Hackney figures based on 2019/20)	*2,743** (Hackney figures based on 2019/20)	2,471	2,213* (aged 17)

Children in need 3-year trend

The total number of children in need at any point in the last three years has increased to 35,740 children, this figure includes children looked after and care experienced young people aged 17 to 21 years of age. Responsibility for care experienced young people can extend to their 25th birthday.
(Hackney numbers have been based on 2019/20 figures)

	Gross Current Expenditure (£'000s)	Number of requests for support received from new clients		New clients with an episode of ST-Max care and a known sequel		Long Term Support during the year		Support provided to carers during the year
		18 to 64	65 and over	18 to 64	65 and over	18 to 64	65 and over	
City and Hackney (figures from 19/20)	£94,902	3,925	2,795	40	230	1,350	2,110	1,595
Tower Hamlets	£109,262	2,965	2,170	105	295	1,735	2,015	1,900
Barking and Dagenham	£65,615	5,770	5,055	190	790	1,195	1,650	1,000
Havering	£76,617	1,290	5,055	120	1,510	1,070	2,610	2,525
Newham	£122,066	3,555	3,845	220	260	2,240	2,620	3,690
Redbridge	£96,884	2,945	6,500	90	665	1,620	2,630	3,695
Waltham Forest	£97,153	2,545	5,460	200	980	1,605	2,160	755
NEL Total	£662,499	22,995	30,880	965	4,730	10,815	15,795	15,160

The north east London health and care system – community care services

Community service mapping – Unplanned / planned

Community Service	Barking & Dagenham	City & Hackney	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest
Unplanned Care services							
2 hour crisis response (Urgent Community Response/Rapid Response)	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Support to nursing homes	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Walk-in centre / UTC /	PELC	Homerton	PELC	BARTS	PELC	BARTS	NELFT
Planned Care Services							
Audiology	Communitas / In Health	InHealth, Scrivens Outside Clinic, Specsavers, RNID	Communitas/In Health	BARTS	Communitas/In Health	BARTS	Scrivens, Outside Clinics, Specsavers
Neurorehabilitation (multi-disciplinary) stroke, head injury and neurological conditions	NELFT/ BHRUT	Homerton	NELFT/BHRUT	ELFT /BARTS	NELFT/BHRUT	BARTS	BARTS
Bedded rehabilitation	NELFT	ELFT	NELFT	ELFT	NELFT	ELFT	NELFT
Community stroke rehab services	NELFT	Homerton	NELFT	ELFT	NELFT	BARTS	BARTS
Community rehab	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Discharge to assess	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
District Nursing	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Early supported Stroke discharge	NELFT	Homerton	NELFT	ELFT	NELFT	BARTS	BARTS
Falls Services	NELFT	MRS independent living	NELFT	ELFT	NELFT	ELFT	NELFT
Integrated discharge	NELFT	Homerton	NELFT	ELFT	NELFT		NELFT
Pall care & EOL - home based	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Pall care & EOL - bed based	Marie Curie / St Francis	St Joseph's	St Joseph's / St Francis	St Joseph's	St Joseph's / St Francis	St Joseph's	St Joseph's

Community service mapping – Adult therapies, equipment & coordination

Community Service	Barking & Dagenham	City & Hackney	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest
Adult therapies							
MSK	NELFT	Homerton	NELFT	BARTS	NELFT	BARTS	BARTS
Nutrution & dietetics	NELFT	Homerton	NELFT	x	NELFT	BARTS	NELFT
Orthotics	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Podiartic surgery	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Podiatry	NELFT	Hoxton Health / Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
SLT	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Equipment and technology							
Assistive teleheath	x	x	x	ELFT	x	x	x
Community equipment	NELFT	Homerton / LA	NELFT	x	NELFT	ELFT	x
Wheelchair services	AJM Wheelchairs	Homerton	AJM Wheelchairs	Enabled living	AJM Wheelchairs	Whizz Mobility	AJM Wheelchairs
specilaist seating	NELFT	x	NELFT	x	NELFT	x	x
Care Coordination							
Care coordination	NELFT	Primary care	NELFT	Coordinated GP fed	NELFT		NELFT
CHC - continuing care packages	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT

Community Service Mapping – specialist services

Community Service	Barking & Dagenham	City & Hackney	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest
Specialist nurses - out side of hospital							
Cardiac rehab	BHRUT	Homerton	BHRUT	ELFT	BHRUT	BARTS	BARTS
Community ENT	Communitas Clinics	Communitas	Communitas Clinics	Communitas	Communitas Clinics	Communitas Clinic	Communitas Clinics
community dermatology	DMC HEALTHCARE LTD	Homerton	MC HEALTHCARE LTD	pt first social enterprise	DMC HEALTHCARE LTD	x	ESS Primary Care Solutions Ltd
Community Gynae	x	Homerton	x	pt first social enterprise	x	x	ESS Primary Care Solutions Ltd
Contienence	AQP WF adults	Homerton	NELFT	x	NELFT	ELFT	NELFT
Community Urology	x	x	x	pt first social enterprise	x	x	x
Diabetes	NELFT	Homerton	NELFT	ELFT	NELFT	BARTS	NELFT
Maintaining Health and Wellbeing including managing long term conditions	NELFT	x	NELFT	x	NELFT	Primary care	x
diabetes education	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Heart Failure	NELFT	Homerton	NELFT	x	NELFT	BARTS	x
Lymphodema	Accelerate	Accelerate	Accelerate	Accelerate	Accelerate	Accelerate	Acclerate
Pain management	x	Homerton / MSK	x	x	x	BARTS	x
Parkinsons servive	NELFT	Homerton	NELFT	x	NELFT	x	x
Phlebotomy	NELFT /PCNs	Homerton / GP Confed	NELFT /PCNs	ELFT /PCNs	NELFT /PCNs	PCNS	NELFT
Home oxygen assessment services	NELFT	Homerton	NELFT	BARTS	NELFT	BARTS	BARTS
Domicilary Phlebotomy	NELFT	GP Confed?	NELFT	ELFT	NELFT	PCNS	NELFT
Pulmonary rehab	NELFT	Homerton	NELFT	ELFT	NELFT	BARTS	NELFT
Respiratory Asthma / COPD / other	NELFT	Homerton	NELFT	x	NELFT	BARTS	NELFT
Sickle servie and Thalassaemia	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT
Spirometry	GP federation	Homerton / GP red	GP federation	Primary care	GP federation	primary care	NELFT
Tissue Viability	NELFT	Homerton	NELFT	ELFT	NELFT	ELFT	NELFT

NHS
North East London

Annex D - transformation portfolio

The transformation portfolio:

1. Our core objectives of high-quality care and a sustainable system

Service area	Programme	Lead system partner	Page*
Urgent and emergency care	Urgent and emergency care	Acute provider collaborative	8
	Enhanced health in care homes	Community collaborative	9
	Ageing well (focussed on urgent community response)		10
	Urgent & emergency care	B&D, Havering, and Redbridge place partnerships	11
	Improving outcomes for people with long term health and care needs - Enhanced community response	City and Hackney Place Partnership	12
	Out of hospital - Unplanned Care, Admission Avoidance	Newham Place Partnership	13
		Tower Hamlets Place Partnership	14
		Waltham Forest Place Partnership	15
	Out of hospital - Unplanned Care (Demand & Capacity)	Newham Place Partnership	16
		Tower Hamlets Place Partnership	17
		Waltham Forest Place Partnership	18
Community health services	Digital community services	Community collaborative	19
	End-of-life care		20
	Post-covid care		21
	Proactive care / Anticipatory care		22
	Virtual wards		23
	Community Health Services Transformation		24
	Out of Hospital Unplanned Care Specialist Pathway Programme (Stroke, Neuro and EOLC)	Newham Place Partnership	25
		Tower Hamlets Place Partnership	26
		Waltham Forest Place Partnership	27

* in the reference pack accompanying this plan

The transformation portfolio:

1. Our core objectives of high-quality care and a sustainable system

Service area	Programme	Lead system partner	Page*
Primary care	Digital First	Primary care collaborative	28
	Same-day access		29
	Tackling unwarranted variation, levelling up and addressing inequalities		30
Planned care and diagnostics	Planned care	Acute provider collaborative	31
Cancer	Cancer alliance		32
Maternity	Maternity		33
	Maternity	NHS NEL	34
	Maternity safety and quality assurance programme	NHS NEL	35

* in the reference pack accompanying this plan

The transformation portfolio:

2. Our NEL strategic priorities

Priority	Programme	Lead system partner	Page*
Babies, children and young people – to make north east London the best place to grow up, through early support when it is needed and the delivery of accessible and responsive services	Developing clearly defined prevention priorities for BCYP	NHS NEL	36
	Community based care	NHS NEL	37
	Vulnerable babies, children and young people	NHS NEL	38
	Babies, children, and young people	Community collaborative	39
	Best chance for babies, children, and young people	Barking and Dagenham place partnership	40
	Children, young people, maternity, and families	City and Hackney place partnership	41
	Childhood immunisations	City and Hackney place partnership	42
	Starting well	Havering place partnership	43
	Autism (ASD) Programme	B&D, Havering, and Redbridge place partnerships	44
	Paediatric Integrated Nursing Service (PINS)		45
	Tier 3 NICE compliant Paediatric Obesity		46
	SEND Therapy Provision		47
	Babies, Children and Young People	Newham place partnership	48
	Born well, grow well	Tower Hamlets place partnership	49
	Babies, children, and young people	Waltham Forest place partnership	50

* in the reference pack accompanying this plan

The transformation portfolio:

2. Our NEL strategic priorities

Priority	Programme	Lead system partner	Page*
Long-term conditions (continued)	CVD	NHS NEL	51
	Diabetes	NHS NEL	52
	Neurosciences	NHS NEL	53
	Renal	NHS NEL	54
	Respiratory	NHS NEL	55
	HIV	NHS NEL	56
	Hepatitis and liver	NHS NEL	57
	Haemoglobinopathy	NHS NEL	58
	Prevention / Prohab	B&D, Havering, and Redbridge place partnerships	59
	Diabetes		60
	Cardiology		61
	Diabetes	Tower Hamlets, Newham and Waltham Forest place partnerships	62
	Cardiology		63
	Respiratory		64
	Improving outcomes for people with long-term health and care needs	City and Hackney place partnership	65
	Enhanced community response	City and Hackney place partnership	66
	Cardiovascular disease prevention	Redbridge place partnership	67

* in the reference pack accompanying this plan

The transformation portfolio:

2. Our NEL strategic priorities → **3. Our supporting infrastructure**

Priority	Programme	Lead system partner	Page*
Mental health – to transform accessibility to, experience of and outcomes from mental health services and well-being support for the people of north east London	Perinatal mental health improvement network	Mental health, learning disabilities, and autism collaborative	68
	IAPT improvement network		69
	Improving health outcomes and choice for people with severe mental illness		70
	Improving outcomes and experience for people with dementia		71
	Crisis improvement network		72
	CYP mental health improvement network		73
	Mental Health	City and Hackney place partnership	74
	Mental health	Havering place partnership	75
	Adult Mental Health	Newham place partnership	76
	Mental Health	Tower Hamlets place partnership	77
	Mental Health	Waltham Forest place partnership	78
Employment and workforce – to work together to create meaningful work opportunities and employment for people in north east London now and in the future	Workforce transformation	NHS NEL	79
Infrastructure	Digital infrastructure	NHS NEL	78
	Physical infrastructure		84

* in the reference pack accompanying this plan

The transformation portfolio:

4. Local priorities within NEL

Led by	Programme	Page*
Acute provider collaborative	Critical care	85
	Research and clinical trials	86
	Specialist services	87
Mental health, learning disabilities, and autism collaborative	Lived experience leadership programme	88
	Learning disabilities and autism improvement programme	89
Barking and Dagenham place partnership	Ageing well	90
	Healthier weight	91
	Stop smoking	92
	Estates	93
City and Hackney place partnership	Supporting with the cost of living	94
	Population health	95
	Neighbourhoods programme	96
Havering place partnership	Infrastructure and enablers	97
	Building community resilience	98
	St George's health and wellbeing hub	99
	Living well	100
	Ageing well	101
Newham	Frailty model	102
	Neighbourhood model	103
	Population growth	104
Newaham	Learning disabilities and autism	105
	Ageing well	106
	Primary care	107
Redbridge place partnership	Health inequalities	108
	Accelerator priorities	109
	Development of the Ilford Exchange	110
Tower Hamlets place partnership	Living well	111
	Promoting independence	112
Waltham Forest place partnership	Centre of excellence	113
	Care closer to home	114
	Home first	115
	Learning disabilities and autism	116
	Wellbeing	117
NHS North East London	Tobacco dependence programme	118
	NEL homelessness programme	119
	Anchors programme	120
	Net zero (ICS Green Plan)	121
	Refugees and asylum seekers	122
	Discharge pathways programme	123
	Pharmacy and Medicine Optimisation/ NEL	124

* in the reference pack accompanying this plan

work in progress

North East London Health & Care Partnership

Joint Forward Plan

Delivering our ambitions through a system transformation portfolio

Transformation portfolio reference document

Third draft: 21 March 2023

The transformation portfolio:

core elements of high-quality care and a sustainable system

North East London Health & Care Partnership

Core elements of high-quality care and a sustainable system (taken from the 'Recovering our core services and improving productivity' section of NHS operating guidance)			
Service area	**Programme**	**Lead system partner**	Page*
Urgent and emergency care	Urgent and emergency care	Acute provider collaborative	8
	Enhanced health in care homes	Community collaborative	9
	Ageing well (focussed on urgent community response)		10
	Urgent & emergency care	B&D, Havering, and Redbridge place partnerships	11
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		Waltham Forest Place Partnership	27

The transformation portfolio: core elements of high-quality care and a sustainable system

North East London Health & Care Partnership

Core elements of high-quality care and a sustainable system (taken from the 'Recovering our core services and improving productivity' section of NHS operating guidance)			
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	Maternity safety and quality assurance programme	NHS NEL	35

The transformation portfolio: additional local strategic priorities

North East London Health & Care Partnership

Additional local strategic priorities			
Priority	**Programme**	**Lead system partner**	Page*
Babies, children and young people – to make north east London the best place to grow up, through early support when it is needed and the delivery of accessible and responsive services	Developing clearly defined prevention priorities for BCYP	NHS NEL	36
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The transformation portfolio: additional local strategic priorities

North East London Health & Care Partnership

Additional local strategic priorities			
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Long-term conditions (continued)	CVD	NHS NEL	51
	Diabetes	NHS NEL	52
	Neurosciences	NHS NEL	53
	Renal	NHS NEL	54
	Respiratory	NHS NEL	55
	HIV	NHS NEL	56
	Hepatitis and liver	NHS NEL	57
	Haemoglobinopathy	NHS NEL	58
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	Enhanced community response	City and Hackney place partnership	66
	Cardiovascular disease prevention	Redbridge place partnership	67

The transformation portfolio: additional local strategic priorities

North East London Health & Care Partnership

Additional local strategic priorities			
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The transformation portfolio: further local priorities

North East London Health & Care Partnership

Further local priorities		
Led by	**Programme**	Page*
Acute provider collaborative	Critical care	85
	Research and clinical trials	86
	Specialist services	87
Mental health, learning disabilities, and autism collaborative	Lived experience leadership programme	88
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	St George's health and wellbeing hub	99
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	Ageing well	101
Newham	Frailty model	102
	Neighbourhood model	103
	Population growth	104

Further local priorities		
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	Ageing well	106
	Primary care	107
Redbridge place partnership	Health inequalities	108
	Accelerator priorities	109
	Development of the Ilford Exchange	110
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Note: further work is being done ahead of the end of March submission on the programme descriptions from the acute provider collaborative, BCYP, LTC – diabetes, and some of the place partnerships

Standard template: transformation in NEL

North East London Health & Care Partnership

Urgent & Emergency Care / Acute Provider Collaborative / SRO: Matthew Trainer, Chief executive Officer, BHRUT matthew/trainer@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Reduced ambulance conveyances to EDs
  - No ambulance handovers over 60 mins
  - Increased access to Same Day Emergency Care (SDEC) across Acute sites
- April 2026:
  - Increased and new community medicine pathways to support out of hospital arrangements where appropriate
  - Increased access via digital to support access to services ie bookable urgent appointments
  - Pipeline of U&EC workforce with clear career/ skills development opportunities across NEL

How this transformation programme reduces inequalities between north east London's residents and communities:

- Increasing equity of access across the geography (front door streaming, SDEC access, optimising pathway 0)
- Through the ambulance flow workstream, working with ambulance Providers, to support Frailty pathways
- Support to patients with Learning Difficulties and Autism accessing U&EC services
- Collaborative working with the Mental Health Collaborative on U&EC pathways for patients

Key programme features and milestones:

U&EC Programme aim to improve equity of access to non-elective care for the population of NEL, deliver short term improvement to BHRUT to support SOF 4, and meet longer term sustainability requirements

Workstream focus on:

- REACH and PRU sustainability and development
- Ambulance flow
- 'front door' working with UTCs
- SDEC
- U&EC workforce - newer roles and CESR training programme
- Urgent diagnostic access
- Optimising pathway 0.

Further transformation to be planned in this area:

- Over the next two years
  - Keeping people safe and well at home: virtual wards, effective falls response, anticipatory care, etc
  - Access to real-time information across the system to support forecast/ demand management
- Over years three to five
  - Further development of virtual consultations for U&EC

Programme funding:

Leadership and governance arrangements:

- Programme Director: Lorna Gibson
- APC U&EC monthly Programme Board
- NHSE Regional reporting – SDEC, UTC

Key delivery risks currently being mitigated:

- Funding for REACH and PRU – evaluation for former underway, and request for both in 23/24 resourcing ask
- Delivery of ambulance flow – funding for HALOs in 23/24 resourcing ask
- Recruitment (to new roles) – funding for Non Clinical Navigators, CESR programme, and U&EC workforce lead
- Programme infrastructure – also in the 23/24 resourcing ask

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Enhanced Health and Care Homes/ Community Collaboratives / Diane Jones, NHS NEL Chief Nursing officer diane.jones11@nhs.net

The benefits that North East London residents will experience by April 2024 and April 2026:

- April 2024:
  - All care homes are aligned to a PCN with a named GP clinical lead via DES contract.
  - All residents in Care Homes have consistent medicines reviews
  - All residents in Care Homes have oral checks and reviews - dental health
  - Comprehensive EHCH strategy supported by Care Home stakeholders in NEL completed with clear delivery action plan
  - Clear alignment and plan in place with digital Strategy and roadmap
  - Formal mapping completed of the gaps for older people at home services in NEL
  - Formal mapping of those in Care settings on the Universal Care Plans
  - Agreement with large providers on reduction of delays into step down care home beds schemes – reduction targets to be agreed per place (Discharge SitRep)
- April 2026
  - Falls prevention, reablement and rehabilitation including strength and balance in place
  - All Care home residents have access to specialist in palliative, EoLC, mental health and dementia care, through existing service resources available to the local population
  - Joined-up commissioning and collaboration between health and social care and at the heart of variation reduction for all services - oral health, service checks
  - All 253 Care Homes providers workforce learning together – significant 7 training across all NEL boroughs and digital platform access
  - Workforce strategy in full swing – apprentice placements plans with local HE Colleges etc.

How this transformation programme reduces inequalities between north east London's residents and communities:

- By 2024, strategy in place designed and supported by resident and Care stakeholders – this will include stakeholder provider and resident voice so NEL can look at outcomes properly
- By 2024, NEL would have mapped all the CORE20plus data it needs to benchmark against delivery for residents impacted most by low quality care and support.
- By 2026, full implementation of the strategy to support reduction in variation cross the offer at place particularly gaps identified in the digital strategy
- By 2026 Providers sharing staff across boundaries improve access to care and support across NEL overall at home or close to home
- Model in place to support improvement in at Home Models of Care and support

Key programme features and milestones:

People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, VCSE sector and care home partners.

- NHS NEL strategy alignment with wider community remit for PEoIC, UCR interfaces i.e. falls prevention and contracts review
- NHS NEL enables DSPT compliant providers can start accessing shared care records for residents starting with UCP.
- At home models of care are being enhanced by local place borough leads i.e. expansion of virtual wards for Care residents

Further transformation to be planned in this area:

Over the next two years

- Completion of deep dive into NEL service Gaps at place
- Support resident and family engagement – how they will feed into developing strategy

Over years three to five

- To have fully embedded co-creation in service design with care providers including joint commissioning

Programme funding:

Since 2021/22 pump prime for 3 years - £8.9m (funding) SDF
2/3 of this budget set to go into baseline 24/25 ICBs – discussion needed on how places intend to continue to afford investment

Leadership and governance arrangements:

- NEL Care Stakeholders Group
- NEL Universal Care Plan (UCP) and care Coordination group.
- Urgent Community Response (UCR) – Programme Delivery Group.

Key delivery risks currently being mitigated:

- Funding for variation reduction work
- More oversight with Care Home partnership

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health		Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce	x	Prevention		Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Ageing well (focussed on urgent community response - Community Based Care / Community Collaborative / SRO TBC

The benefits that North East London residents will experience by April 2024 and April 2026:

April 2024:

- Constituently meeting 70% + UCR target NEL target is 90% meet trajectory count of 9995 residents supported 23/24
- Data mapping on the impact UCR is having on reduction in ED admissions
- Implementation of virtual ward interfaces and more digital interoperability

How this transformation programme reduces inequalities between north east London's residents and communities:

- Increase patient choice into rapid response in the community for older people
- This will help ensure we are working with local people to get them on pathways that reduces wait times in ED especially high intensity users
- Focuses on population considered in CORE20plus and over time will focus on this cohort in terms of falls prevention, delirium – 9 clinical standards
- This will provide residents with more timely assessment for their conditions underpinned by digital and more appropriate close to home options
- All residents will get the same / similar care wherever they live in NEL. This will be assessed over time as we deep dive on outcomes

Key programme features and milestones:

- 9995 residents supported by the end of 23/24 in accordance with trajectory for the service
- Mapped and done deep dive into resident experiences across the UCR pathway to reduce variation
- All data quality issues resolved and NEL consistently reporting data next 3, 6 and 12 months across all providers
- Electronic Single Point of access pull Pilot to increase count of residents accessing the service via 111/999 triage

Further transformation to be planned in this area:

- Over the next two years
  - Develop and implement a growth approach for UCR capacity
  - Develop pipeline workforce for the teams i.e. apprentices, rotations
  - Join up pathways including access to UCR virtual wards with existing pathways to maximise
  - Look more closely at service variation in terms of cost of the service and work with providers to improve their outcomes

  Over years three to five:
  - Consider reducing variation by look at provider contracts and where we can maximize value for residents

Programme funding: NHSE (National Funding)

- Since 2021/22 pump prime for 3 years - £8.9m (funding) SDF
- 2/3 of this budget set to go into baseline 24/25 ICBs can focus on this or other areas of choosing but they must maintain 70%+ UCR target

Leadership and governance arrangements:

- ICB programme Delivery Support
- Community Based Care
- Task & Finish Groups for Delivery Oversight with providers
- Operations Working Group – Trajectory, Capacity and Delivery Monitoring

Key delivery risks currently being mitigated:

- Variation of the way service is configured across NEL provision
- Workforce
- Work on interfaces i.e. Virtual Wards connectivity
- Comms and engagement to promote the service - need additional support so care homes, primary care and other parts of system think UCR first
- Digital connectivity with LAS / UCR – this will be explored in Pilot

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Urgent & emergency care / Barking and Dagenham, Havering, and Redbridge place partnerships / SRO TBC

The benefits that north east London residents will experience by April 2024 and April 2026:

April 2024:

- 76% of patients to be treated and discharged or admitted through ED within 4 hours
- Continue to exceed the 70% target for patients seen in 2 hours by UCR service
- Patients attending UTCs are streamed in 15 mins and 98% are treated in 4 hours
- Virtual Ward Capacity will be available to support people to stay at home rather than be admitted to an acute bed

April 2026:

- Align with transformational programmes or pathways such as virtual wards and introduce integrated working amongst partner organisations
- More people managed safely in the community as an alternative to ED / acute admission
  - Increased - supported by appropriate use of technology
  - Increased range of clinical conditions to meet assessed need

How this transformation programme reduces inequalities between north east London's residents and communities:

- By ensuring unnecessary admissions are prevented resulting in reduced LAS call-outs, conveyances and length of stays with residents maintained in their place of residence
- By working collaboratively in a multi-disciplinary admissions in A&E are reduced and residents are treated by the right team of professionals in the right setting
- By improving access to general practice residents, will be managed by the most appropriate clinician where necessary
- By using population health data to target investment in areas of greatest assessed need

Key programme features and milestones:

- BHRUT/ PELC Front Door Programme to bring relevant stakeholders together, identify key issues and work collaboratively to provide solutions (Q1)
- UTC services – improvement in waiting times and patient experience (Q2)
- Integrated Discharge hub service review and implementation of service changes to better meet patient need (Q2)
- Implementation of virtual wards (Q1)
- Review of UCR service and increase capacity through revised staffing model (Q3)
- Ongoing monitoring of LAS Care Homes report providing oversight of call-outs/conveyances (ongoing)
- Primary care access to SDEC (Q3)
- Proactive planning for Winter & known times of pressure

Further transformation to be planned in this area:

- Over the next two years
  - ➢ Increase in 111 direct booking capacity
  - ➢ Expansion of the HIU model
  - ➢ Improve recording/capturing of SDEC data
- Over years three to five
  - ➢ Improve experience when accessing primary care

Programme funding:

- *Aging well*
- *Virtual ward SDF*
- *Demand and capacity*
- *ASC Discharge Fund*

Leadership and governance arrangements:

- NEL Urgent care Board
- BHR Places UEC Improvement Board
- Borough Partnership Boards
- PELC Assurance group

Key delivery risks currently being mitigated:

- Workforce/retention challenges, i.e. shortage of therapists and nurses in secondary, community and primary care
- Insufficient funding to deliver complex model
- Cost of living pressures – impact on delivery of care in the home environment
- Risk of digital exclusion as models develop and become more reliant on technology to support delivery
- Winter pressures/Flu

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Improving outcomes for people with long term health and care needs - Enhanced community response / City and Hackney place partnerships / SRO TBC

The benefits that City and Hackney residents will experience by April 2024 and April 2026:

April 2024:
- Consistent access to urgent community response as a safe alternative to ED for patients in crisis
- Access to a frailty and respiratory virtual ward as a safe alternative to hospital admission
- Better continuity of care post crisis to ensure complete recovery and reduce risk of further crisis

April 2026:
- More people managed safely in the community as an alternative to ED / acute admission
  - Increased - supported by appropriate use of technology
  - Increased range of clinical conditions to meet assessed need
- Fewer people experiencing crisis
- Increased patient choice and personalised care at home

How this transformation programme reduces inequalities between north east London's residents and communities:
- By supporting vulnerable frail cohort to receive consistent acute level care in their own homes
- By ensuring equity of access and supporting referrals from system partners
- By reducing variation in avoidable use of urgent and emergency care services including LAS and ED
- By providing flexible employment opportunities
- By using population health data to target investment in areas of greatest assessed need

Key programme features and milestones:

Urgent community response
- Robust delivery of 2 hour crisis response standard.
- Maximising referrals from all sources – including LAS and self-referral
- Explore need / potential impact of extended hours and broadened scope
- Evaluating impact and outcomes
- Developing interface with emerging virtual wards

Virtual wards
- Partnership collaboration to design and implement virtual ward model for clinical priority areas of Frailty and ARI.
- Develop a sustainable workforce model that supports the clinical pathways as they mature
- Exploring potential need / opportunity to broaden scope of virtual ward provision

Further transformation to be planned in this area:

Over the next two years
- Develop a sustainable model of care for virtual wards
- Join the virtual wards with existing pathways to maximise admission avoidance and early supported discharge
- Work with digital teams to understand how to maximise benefits with tech enablement

Over years three to five
- ➢ Broaden scope and capacity within UCR and Virtual wards
- ➢ Integration with Neighbourhoods & proactive care model to maximise prevention

Programme funding:
- Ageing Well & Virtual Ward service development funding
- Existing service budgets

Leadership and governance arrangements:
- C&H Place Based Partnership Delivery Group and Health and Care Board
- NEL Community Based Care Programme Board / Community Health Collaborative

Key delivery risks currently being mitigated:
- Insufficient suitably qualified workforce to deliver new models
- Insufficient funding to deliver complex model
- Cost of living pressures – impact on delivery of care in the home environment
- Risk of digital exclusion as models develop and become more reliant on technology to support delivery

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Out of hospital - Unplanned Care, Admission Avoidance / Newham place partnerships / SRO TBC

The benefits that Newham residents will experience by April 2024 and April 2026:

- April 2024:
  - 70% of residents seen within 2-hours by rapid response (UCR standard)
  - Residents identified as high intensity users or frequent attenders have access to a multi-disciplinary team
  - Increase access to a GP consultation through NHS 111 direct booking
  - Virtual Ward Capacity will be available to support people to stay at home rather than be admitted to an acute bed
- April 2026:
  - Align with transformational programmes or pathways such as virtual wards
  - Expand service to cover residents stratified as medium risk of frequent attendance
  - Achieve 90% utilisation of NHS 111 direct booking capacity available in general practice

How this transformation programme reduces inequalities between north east London's residents and communities

- By ensuring unnecessary admissions are prevented resulting in reduced LAS call-outs, conveyances and length of stays with residents maintained in their place of residence
- By ensuring services working with a common caseload adopt an integrated approach to provide holistic care
- By working collaboratively in a multi-disciplinary admissions in A&E are reduced and residents are treated by the right team of professionals in the right setting
- By improving access to general practice residents, will be managed by the most appropriate clinician where necessary

Key programme features and milestones:

- Undertake evaluation of existing model to determine if the service is seeing the right cohort and has the right staffing model (August 2023)
- Write service specification and formalise monitoring arrangements for HIU (August 2023)
- Update service specification for Rapid Response (April 2023)
- Audit utilisation of NHS 111 capacity and target practices requiring support
- Procurement of joint Marie Curie Night Sitting Service

Further transformation to be planned in this area:

- Over the next two years
  - Increase in 111 direct booking capacity
  - Expansion of the HIU model to include residents who are medium risk
- Over years three to five
  - Improve experience when accessing primary

Programme funding:

- Ageing Well
- Virtual Ward

Leadership and governance arrangements:

- Newham Urgent Care Working Group
- Newham Front Door Programme
- Newham Admission Avoidance Group

Key delivery risks currently being mitigated:

- Workforce – National shortage of nurses, physios, therapists
- Winter pressures, Flu, COVID
- Recurrent funding
- Data quality

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Out of hospital - Unplanned Care, Admission Avoidance / Tower Hamlets place partnership / SRO TBC

The benefits that Tower Hamlets residents will experience by April 2024 and April 2026:

- April 2024:
  - 70% of residents requiring 2-hour urgent community response are seen
  - Residents identified as high intensity users or frequent attenders have access to a multi-disciplinary team
  - Increase access to a GP consultation through NHS 111 direct booking
  - Virtual Ward Capacity will be available to support people to stay at home rather than be admitted to an acute bed
- April 2026:
  - Align with transformational programmes or pathways such as virtual wards and introduce integrated working amongst partner organisations
  - Expand service to cover residents stratified as medium risk of frequent attendance
  - Achieve 90% utilisation of NHS 111 direct booking capacity available in general practice

How this transformation programme reduces inequalities between north east London's residents and communities

- By ensuring unnecessary admissions are prevented resulting in reduced LAS call-outs, conveyances and length of stays with residents maintained in their place of residence
- By ensuring services working with a common caseload adopt an integrated approach to provide holistic care
- By working collaboratively in a multi-disciplinary admissions in A&E are reduced and residents are treated by the right team of professionals in the right setting
- By improving access to general practice residents, will be managed by the most appropriate clinician where necessary

Key programme features and milestones:

- Undertake evaluation of existing model to determine if the service is seeing the right cohort and has the right staffing model (September 2023)
- Write service specification and formalise monitoring arrangements for HIU (August 2023)
- Update service specification for Rapid Response (April 2023)
- Audit utilisation of NHS 111 capacity and target practices requiring support (March 2023)

Further transformation to be planned in this area:

- Over the next two years
  - Increase in 111 direct booking capacity
  - Expansion of the HIU model to include residents who are medium risk
- Over years three to five
  - Improve experience when accessing primary

Programme funding:

- Ageing Well for Rapid Response
- Virtual Ward Funding

Leadership and governance arrangements:

- Tower Hamlets Urgent Care Working Group
- Royal London Hospital Front Door Programme

Key delivery risks currently being mitigated:

- Workforce – National shortage of nurses, physios, therapists
- Winter pressures, Flu, COVID
- Use of digital as an enabler for direct booking into Rapid Response
- Data quality

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Out of hospital - Unplanned Care, Admission Avoidance / Waltham Forest place partnership / SRO TBC

The benefits that Waltham Forest residents will experience by April 2024 and April 2026:

- April 2024:
  - Ensure the 70% 2-hour urgent community response standards is achieved or exceeded
  - Residents identified as high intensity users or frequent attenders have access to a multi-disciplinary team
  - Increase access to a GP consultation through NHS 111 direct booking
  - Virtual Ward Capacity will be available to support people to stay at home rather than be admitted to an acute bed
- April 2026:
  - Align with transformational programmes or pathways such as virtual wards and introduce integrated working amongst partner organisations
  - Expand service to cover residents stratified as medium risk of frequent attendance
  - Achieve 90% utilisation of NHS 111 direct booking capacity available in general practice

How this transformation programme reduces inequalities between north east London's residents and communities

- By ensuring unnecessary admissions are prevented resulting in reduced LAS call-outs, conveyances and length of stays with residents maintained in their place of residence
- By ensuring services working with a common caseload adopt an integrated approach to provide holistic care
- By working collaboratively in a multi-disciplinary admissions in A&E are reduced and residents are treated by the right team of professionals in the right setting
- By improving access to general practice residents, will be managed by the most appropriate clinician where necessary

Key programme features and milestones:

- Undertake evaluation of existing model to determine if the service is seeing the right cohort and has the right staffing model (August 2023)
- Write service specification and formalise monitoring arrangements for HIU (August 2023)
- Update service specification for Rapid Response (April 2023)
- Audit utilisation of NHS 111 capacity and target practices requiring support (April 2023)
- Ongoing monitoring of LAS Care Homes report providing oversight of call-outs/conveyances (ongoing)
- Establish T&F Group for Waltham Forest Admission Avoidance Group (completed)

Further transformation to be planned in this area:

- Over the next two years
  - Increase in 111 direct booking capacity
  - Expansion of the HIU model to include residents who are medium risk
- Over years three to five
  - Improve experience when accessing primary

Programme funding:

- Ageing Well
- Virtual Ward SDF

Leadership and governance arrangements:

- Waltham Forest Urgent Care Working Group
- Whipps X Front Door Programme
- Home First Executive

Key delivery risks currently being mitigated:

- Workforce – National shortage of nurses, physios, therapists
- Winter pressures, Flu, COVID
- Data quality

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Out of hospital - Unplanned Care (Demand & Capacity) / Newham place partnership / SRO TBC

The benefits that Newham residents will experience by April 2024 and April 2026:

- April 2024:
  - Improve the access for urgent treatment for our patients
  - Working collaborative with providers to ensure the best care and patient experience for our residents
  - Defining the acute operating model of Emergency Care Same Day Emergency Care (SDEC) and Urgent Treatment Centre (UTC) compliant to national standards
- April 2026:
  - Ensure clinically appropriate patients are seen in the right place at the right time
  - Increase collaborative working to deliver improved care and targeting the needs for our residents
  - Alignment of services across the Barts Hospital sites to Same Day Emergency Care (SDEC) and Urgent Treatment Centres (UTC) to ensure consistent offer

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing the number of urgent care attendances and admissions for treatments that are best accessed out of hospital – Primary Care and Community
- By reducing admissions and length of stays with patients seen and treated via SDEC
- By improving pathways into Secondary Care and discharged into Primary Care and the Community
- By supporting changes in the 111 DOS profiles so residents are referred for their appropriate care
- By ensuring and improving engagement between Acute and Primary Care Clinicians/Clinical Leads
- By ensuring shared learning across the NEL system

Key programme features and milestones:

- Newham Front Door Programme to bring relevant stakeholders together, identify key issues and work collaboratively to provide solutions
- Ensure best practice is adopted across urgent and emergency care
- Use the UTC Scorecard to monitor activity/trends and put in plans to proactively manage demand
- Improve GP/Primary Care access to SDEC
- Identify and agree key priorities/plan to support with children and young people (CYP) frequent attenders to A&E – work in progress
- Review of plans to support with 75% including streaming
- Local system review of wound care provision and plan for appropriate referral into the community/primary care rather then followed up in the UTC – working closely with the Primary Care Team – work in progress
- Proactive planning for Winter and known times of surge and pressure

Further transformation to be planned in this area:

- Over the next two years
  - Improve recording/capturing of SDEC data
  - Develop demand management schemes
- Over years three to five
  - Improve patient experience when accessing urgent care

Programme funding:

- X

Leadership and governance arrangements:

- Newham Urgent Care Working Group
- Newham Front Door Programme

Key delivery risks currently being mitigated:

- Workforce/retention challenges, i.e. shortage of nurses in secondary and primary care
- Challenges with estates/sites to cope with high level of patient activity
- Difficulty in accessing GP/Primary Care appointments on the same day due to patient demand
- Winter pressures/Flu
- Limited engagement from clinical leads/providers and resistance to change

Transformation in NEL

North East London Health & Care Partnership

Out of hospital - Unplanned Care (Demand & Capacity) / Tower Hamlets place partnership / SRO TBC

The benefits that Tower Hamlets residents will experience by April 2024 and April 2026:

- April 2024:
  - Improve the access for urgent treatment for our patients
  - Working collaborative with providers to ensure the best care and patient experience for our residents
  - Defining the acute operating model of Emergency Care Same Day Emergency Care (SDEC) and Urgent Treatment Centre (UTC) compliant to national standards
- April 2026:
  - Ensure clinically appropriate patients are seen in the right place at the right time
  - Increase collaborative working to deliver improved care and targeting the needs for our residents
  - Alignment of services across the Barts Hospital sites to Same Day Emergency Care (SDEC) and Urgent Treatment Centres (UTC) to ensure consistent offer

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing the number of urgent care attendances and admissions for treatments that are best accessed out of hospital – Primary Care and Community
- By reducing admissions and length of stays with patients seen and treated via SDEC
- By improving pathways into Secondary Care and discharged into Primary Care and the Community
- By supporting changes in the 111 DOS profiles so residents are referred for their appropriate care
- By ensuring and improving engagement between Acute and Primary Care Clinicians/Clinical Leads
- By ensuring shared learning across the NEL system

Key programme features and milestones:

- Royal London Front Door Programme to bring relevant stakeholders together, identify key issues and work collaboratively to provide solutions – initial workshop took place to discuss key priorities
- Ensure best practice is adopted across urgent and emergency care
- Use the UTC dashboard to monitor activity/trends and put in plans to proactively manage demand
- Improve GP/Primary Care access to SDEC
- Review of plans to support with 75% including streaming
- Proactive planning for Winter and known times of surge and pressure

Further transformation to be planned in this area:

- Over the next two years
  - Improve recording/capturing of SDEC data
  - Review of the UTC model at Royal London
- Over years three to five
  - Improve patient experience when accessing urgent care

Programme funding:

- X

Leadership and governance arrangements:

- Tower Hamlets Urgent Care Working Group
- Royal London Front Door Programme

Key delivery risks currently being mitigated:

- Workforce/retention challenges, i.e. shortage of nurses in secondary and primary care
- Challenges with estates/sites to cope with high level of patient activity
- Difficulty in accessing GP/Primary Care appointments on the same day due to patient demand
- Winter pressures/Flu
- Limited engagement from clinical leads/providers and resistance to change

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Out of hospital - Unplanned Care (Demand & Capacity) / Waltham Forest place partnership / SRO TBC

The benefits that Waltham Forest residents will experience by April 2024 and April 2026:

- April 2024:
  - Improve the access for urgent treatment for our patients
  - Working collaborative with providers to ensure the best care and patient experience for our residents
  - Defining the acute operating model of Emergency Care Same Day Emergency Care (SDEC) and Urgent Treatment Centre (UTC) compliant to national standards
- April 2026:
  - Ensure clinically appropriate patients are seen in the right place at the right time
  - Increase collaborative working to deliver improved care and targeting the needs for our residents
  - Alignment of services across the Barts Hospital sites to Same Day Emergency Care (SDEC) and Urgent Treatment Centres (UTC) to ensure consistent offer

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing the number of urgent care attendances and admissions for treatments that are best accessed out of hospital – Primary Care and Community
- By reducing admissions and length of stays with patients seen and treated via SDEC
- By improving pathways into Secondary Care and discharged into Primary Care and the Community
- By supporting changes in the 111 DOS profiles so residents are referred for their appropriate care
- By ensuring and improving engagement between Acute and Primary Care Clinicians/Clinical Leads
- By ensuring shared learning across the NEL system

Key programme features and milestones:

- Whipps X Front Door Programme to bring relevant stakeholders together, identify key issues and work collaboratively to provide solutions
- Ensure best practice is adopted across urgent and emergency care
- Agree for children and young people (CYP) for a paediatric/family liaison role in Whipps X A&E to support with frequent attenders – work in progress
- Internal review of UTC capacity/site to enable them to accept more clinical appropriate activity i.e. 111 direct booking and from minors
- Review of plans to support with 75% including streaming
- Improve GP/Primary Care access to SDEC
- Proactive planning for Winter and known times of surge and pressure

Further transformation to be planned in this area:

- Over the next two years
  - Improve recording/capturing of SDEC data
  - Expansion of the UTC footprint within Whipps X Hospital (Area A)
  - Increase in 111 direct booking capacity
- Over years three to five
  - Improve patient experience when accessing urgent care

Programme funding:

- X

Leadership and governance arrangements:

- Waltham Forest Urgent Care Working Group
- Whipps X Front Door Programme
- Whipps X Redevelopment Programme

Key delivery risks currently being mitigated:

- Workforce/retention challenges, i.e. shortage of nurses in secondary and primary care
- Challenges with estates/sites to cope with high level of patient activity
- Difficulty in accessing GP/Primary Care appointments on the same day due to patient demand
- Winter pressures/Flu
- Limited engagement from clinical leads/providers and resistance to change

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Digital Programme: Community-based care / NEL / Niall Caravan

The benefits that north east London's residents will experience by April 2024 and April 2026 :

April 2024:
- Residents will benefit from joined up conversations, that mean they do not have to repeat their story, through
  - the mobilisation of a digital framework for wider community and social care providers to enable them to build interoperable capability quickly
  - One shared care record to include Universal Care Plans across main health and care settings in NEL

April 2026:
- Shared Care Record for health and social care leading to reduction in duplicate records across all health and social care for residents including better feedback loops for residents and stakeholder providers – Social Services, rest other relevant services (50)
- Interactive services for residents in NEL go live in NHS App
- Improved outcomes for residents as Integrated workforce digital solutions across health and social care for main providers go live

How this transformation programme reduces inequalities between north east London's residents and communities:
- By rolling out next scale phase of the NEL shared care record across Care Homes and Social Care Providers to reduce access barrier issues for residents
- By implementing the Core20PLUS5 approach as priority areas of service line focus when it comes to record sharing and focus areas for services for example adding diabetes records
- By ensuring residents from a range of backgrounds are included in the design and improvement of digital tools we will reduce the barriers to support
- We aim to review then reduce differences in what residents get digitally across our places at regional, borough and neighbourhood level

Key programme features and milestones:

Building tools that enable providers and residents to co-produce and create care support.

- Streamline flow of information to enable a more seamless experience for residents but also stakeholders in the care of residents
- Better feedback mechanism to residents
- Reduce administrative time for those working across boundaries
- Give patients and (with patient consent) carers and clinicians involved in their care, better access to their care record -Incomplete referral forms lead to increased admin burden, and longer patient waiting times and pose safeguarding and clinical risks

Further transformation to be planned in this area:
- Over the next two years
  - Roll-out of Universal Care Plan to Dom Care
  - Roll-out of Shared Care Record to wider community providers
  - Portal for wider system to know what digital tools we have already they can plug-into (opportunities)
- Over years three to five
  - Integrated workforce tools across health and care

Programme funding:
- Programme lead role (Ageing Well Baseline)
- NHSE funds for Shared Care Record roll out
- EPR funding
- Awaiting digital transformation announcement

Leadership and governance arrangements:
- NEL Digital Board
- NEL Community Collaborative
- NEL Community Digital Delivery Group (including NEL ICB Delivery Leads)

Key delivery risks currently being mitigated:
- IG readiness for wider integrations – playing catch up with legal changes
- Unknown funding timelines for the wider system workstreams

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Palliative end of life / Community collaborative / Nina Griffith, Workstream Director, NHS NEL, nina.griffith@nhs.net

The benefits that North East London residents will experience by April 2024 and April 2026:

April 2024:
- All residents (including all groups) involved at all levels on what good PEolC and good death means and looks like
- All boroughs have same access to palliative end of life care services via clear online navigation into relevant services.
- All boroughs to have same services available to their residents including children, ethnic minority, poverty, language barrier etc. More work done to enable VCS to support this delivery
- All residents accessing and feeding into their Universal Care Plan via NHS App
- All providers accessing same data for resident for planning via the Universal Care Plan
- 500+ Generalist staff trained on End of life care including managing Eolc conversations with residents
- Clinical staff will have basic end of life care training as part of the statutory and mandatory learning when they work in NEL.

April 2026:
- All of NEL have bereavement services led by joint work with VCSs (Contract/s)
- 2000 Generalist staff trained on a range of Palliative End of life care delivery areas including identification and clinical and care deliverables 0.3% identification of PEolC residents (this is presently 0.22%)
- Prevention of a percentage of admissions for PEolC agreed once data models are done
- Standardised quality of care and access across NEL including children, ethnic minority, poverty, language barrier etc

How this transformation programme reduces inequalities between north east London's residents and communities:
- 2024, this transformation programme would allow us to ensure service lines are the same across all groups and across board which reduces inequalities
- 2024, it will allow us to develop a range of community based care and support packages and services across NEL with existing and new contracts and new partnerships
- 2024 we will have a representative sample of resident voices from our communities involved in how services are accessed, run, and joined up. These voices to include faith, LGBTQ, homeless and ethnic minority communities
- 2024, as part of engagement with our communities we will have a thorough understanding of where service provision is inconsistent across NEL. An action plan will be developed on how we can address this under provision.
- 2026, we would be able to develop and assess PEoL clinical and non-clinical services for local communities ensuring we reduce variation and inequalities both within services and for communities.
- 2026, we would be able to use data to monitor programmes across all EoI services, understand the impact of commissioned services on patient outcomes and set targets for quality of care; having a coordinated plan for the future.

Key programme features and milestones:
- NEL Frailty, PEoLC Community Dashboard
- Completion of the Ambitions toolkit - a national requirement to assess NEL EoI care services against the ambitions set out in the framework.
- Full stocktake and deep dive report of services across NEL which reviewed NEL's current position on PEolC.
- NEL PEoLC Strategy which includes resident engagement
- Development of a PEolC strategy for North East London which includes resident engagement.
- Hospice sustainability for CYP and adult in North east London- NEL will be one of the first ICBs to commission Specialist Palliative and EoI services using a collaborative approach to build sustainability in their funding.
- Deep and continuous resident engagement across NEL by mid-2023, comprising in workshops / focus groups, more detailed survey to understand provision of PEolC across NEL.
- Ongoing dialogue and strengthening of relationship with VCS and Healthwatch.

Further transformation to be planned in this area:

Over the next two years
- Joined up work with cancer alliance and community collaboratives
- Further Children and ,young person joined up working
- Virtual beds/Hospice at home pathways
- Bereavement service accessible for all NEL
- Completion of all phases of the NEL data dashboard
- Further engagement with ethnic minority, LGBTQ, faith, homeless and other priority groups

Over years three to five
- Delivery driven through strong relationships with our local partners
- To have fully embedded co-creation in service design
- NEL meets 0.5% population target identified for PEolC

Programme funding:
- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:
- NEL PEolC Programme Group
- NEL Universal Care Planning (UCP) and care Coordination group
- Urgent Community Response (UCR) – Programme Delivery Group
- NEL Cancer Program
- NEL Children's Group

Key delivery risks currently being mitigated:
- Workforce and training
- Education
- Transformation envelope in the ICB enable changes
- Engagement activity not being as representative with the population meaning full range of community voices not incorporated

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health		Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce	x	Prevention	X	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Post Covid / Rehabilitation : Community-based care / Community Collaborative / Dr Stephanie Coughlin, GP and Clinical Project Sponsor, stephaniecoughlin@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - All NEL Staff and residents easily able to quickly access pathway from their GP within the recommended 4-10 weeks after persistent ongoing symptoms
  - Residents can Access specialist services less than 4 weeks from GP referral
- April 2026:
  - Long Covid service becomes part of BAU offer within our community provision (contracts)
  - Reduced number of unplanned admissions to hospital of residents with long-covid
  - All residents that need the service will know how to access long Covid specialist service

How this transformation programme reduces inequalities between north east London's residents and communities:

- We will be using data to continue to map who is accessing our post Covid services particularly communities we know are already finding access hard this will enable us to see how local outreach interventions are working
- We are focused on both physical and mental health using deep dives with Healthwatch to look at impacts being made – two baseline reports already conducted will be followed up in 23/24
- There is a commitment across all places to review outcomes as providers prepare for national inquiry focus on diagnosis, treatment and current support available to those with long COVID.

Key programme features and milestones:

Ensure there are no barriers to access post Covid services and support across NHS NEL. Reduction of variation of all our services. Continue to build community engagement.

- Ensuring all GPs are referring residents appropriately into the pathway
- We will be working with community outreach to ensure hard to reach communities know about the service using a range of support tools to reach out – videos, languages/ translations.
- Major element will be as a system look at the variation residents are getting closing these down so people feel they are getting like for like wherever they live.

Further transformation to be planned in this area:

- Over the next two years
  - Maximising the use of digital tools
  - Ensure that the Integrated child health models/family hubs are aligned with the Nurse roles being part of that wider long Covid MDT team at place ensuring young people get similar offer
- Over years three to five
  - Build the wider linked social prescribing offer at place
  - Strengthen adolescent healthcare in the pathway

Programme funding:

- System Development Funding (SDF) 3+million then baseline likely or PBR by 2025 and beyond.
- Funds will therefore can be viewed as recurrent for foreseeable future

Leadership and governance arrangements:

- NEL Post Covid Delivery Group
- NEL Community Health Collaborative
- NEL Community Health Programme Board
- Provider/ Place leads

Key delivery risks currently being mitigated:

- Workforce development
- Transition to BAU

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care		High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention		Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Proactive Care (formerly Anticipatory Care) / Community Based Care/ Collaborative / SRO TBC

The benefits that North East London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Residents with two or more long-term health conditions who are either frail or reliant on unplanned care or experiencing health inequalities are proactively identified and offered a proactive care assessment. This enables patient goals to be set to maintain good health and put measures in place to prevent ill-health from developing and reducing the need for health and social care. – Model Numbers agreed and tested across our places
  - Residents who accept proactive care assessments will have poor health prevented from escalating to the point of requiring health and/ or social care support through MDT working with integrated neighbourhood teams.
  - A holistic proactive assessment which covers quality of life, employment, mini-geriatric assessment, nutrition, hydration, physical activity, mental wellbeing.
- April 2026:
  - All NEL residents in scope have an equitable offer of Proactive Care no matter where they live this is mapped out numerically by place with clear trajectories and resident impacts per place also modelled (NEL to agree its numbers once NHSE have set national targets)
  - Model mapped against admissions avoidance schemes with a focus on LTCs prevention (target to be developed)
  - Proactive Care will focus more broadly than just the original cohort of patients as specified by NHS England. Therefore expanding the inclusion criteria and enabling more NEL residents to have a proactive care assessment.

How this transformation programme reduces inequalities between north east London's residents and communities:

- Proactive care proactively identifies population considered in CORE20plus cohort. Therefore, by ensuring an equitable model of care is delivered in NEL, residents will have equitable access and opportunity to be invited for a proactive care assessment.
- Proactive care is a holistic model, therefore a holistic comprehensive assessment of the residents life is considered, this ranges from a mini geriatric assessment to assessment of quality of life. This may include identifying housing issues, for example damp conditions may cause respiratory problems and cause long-term absences from paid employment. Many Proactive Care models across North East London have invited a member of staff from the local authority housing team and therefore we can identify and raise with Housing teams where poor housing is present benefiting the health and social care system. Similarly, where a resident may be unemployed and is seeking employment, the proactive care assessment may identify health barriers which can be removed to enable that individual back in to work and therefore improving the wider determinants of health by enabling residents to access employment which may not have previously been possible.
- National evidence shows that care home admissions can be reduced by 30%, per proactive care assessment one less hospital admission can be forecast, improvements in quality of life and employment opportunities. NEL will be working with BI to review a range of opportunities to support residents stay well for longer by being supported.

Key programme features and milestones:

- Residents who are considered the 'rising risk' population are proactively identified and offered a proactive care assessment.
- A personalised care approach is taken with residents, this means that factors which need to be in place to maintain good levels of health and wellbeing are identified collaboratively.
- Where appropriate, the personalised care and support plan is discussed at an MDT, where there are truly integrated teams around the table including the voluntary sector and social care teams.
- Proactive Care operates via working in Integrated Neighbourhood Teams, therefore creating job satisfaction and retention for staff through opportunities for development, MDT working and effective co-ordination
- **By November 2023** all models will have evaluated delivery and chosen optimal operating model.
- **By December 2023** a consensus will be reached as to the way in which Proactive Care will be delivered in NEL with minimal unwarranted variation at Place.
- **By April 2024** BI will support case for change mapped against reduction in hospital admissions and growth of workforce in community

Further transformation to be planned in this area:

- Over the next two years:
  - Once established with basic cohort recommended by NHS E (frailty, unplanned care, health inequalities) NEL will establish its Population Health Cohort working with in-house BI teams to identify at risk residents beyond the national cohorts.
  - Population Health Management system to identify residents that need early interventions
- Over years three to five:
  - Integrate with hospital discharge process to reduce number of avoidable re-admissions
  - Fully integrated process with social care assessments and digital tools

Programme funding: Ageing Well (SDF) 21/22, 22/23, 23/24 Pilots

- **City and Hackney:** (Y1) - £121,000, (Y2) - £1,259,246, (Y3) - £473,109, (Y4 24/25) - £0 Awaiting national directive on additional funds including Arrs roles but also local decisions on baseline and uplift investments
- **Barking, Havering and Redbridge:** (Y1) - £2,843,682, (Y2) - £1,272,977, (Y3) - £1,272,977, (Y4 24/25) – As above
- **Tower Hamlets, Newham and Waltham Forest:** Majority of funding went into UCR uplifts to level out NEL service provision, onal targets. As above moving into

Leadership and governance arrangements:

- Programme Transformation Support and Assurance ICB
- Place Based Leads in each Place ICB facing borough partnership
- Currently reporting in to the Community Based Care Programme
- Collaborative Board

Key delivery risks currently being mitigated:

- There inequity of funding between TNW, BHR
- WF borough has however tested quite advanced set up of the social prescriber model in collaboration with PCN MDTs and NELFT spearheaded by Bromley by Bow.
- Ageing Well SDF goes into baselines and uplifts 24/25. There is work being done to mitigate the funding gap with joined up working across primary care ARRS roles and model – this along with join up with Fuller is also being looked at by the national team
- Clinical leadership at NEL level needed – place clinical leads in place. This is presently being looked at for best fit.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

NEL Virtual Ward / Community Based Care / Community Collaborative/ SRO TBC

The benefits that North East London's residents will experience by April 2024 and April 2026:

April 2024:

- Residents across NEL will have a access to a consistent Virtual Ward offer regardless of where they live – led by Community Collaborative
- Integrated models between acute and community provision at least 551 VW beds
- Assessment & care provided by MDT from range of community services
- Clinical oversight from relevant acute consultants
- Focused on admission avoidance but potential to accept expedited discharge
- Offers timely face to face assessment where required. Max LOS 14 days
- Referrals from GP, Neighbourhood/community teams, Urgent community response services, Emergency departments and Wards starting to come in
- New referrals accepted and assessed within core hours – 24/7 wrap around care provided by existing out of hours provision
- Clinically led design principles will be used in setting out on boarding and discharge criteria

April 2026:

- Model for ED admissions drop in place mapped by place
- Care plan – follow up/ support required determined by clinical and care needs identified at assessment
- Include self-management – some form of self-review with clear advice / process to follow in response to findings. Potential to develop this feature with enabling technology

How this transformation programme reduces inequalities between north east London's residents and communities:

- This programme increase patient choice given them personalised care using digital tools where applicable to enable this, allowing patients to be treated in a more comfortable at home or close to home environment
- This will help ensure we are working with local people to get them on pathways that reduces wait times in ED
- This will provide residents with more timely assessment for their conditions underpinned by digital
- The Community Collaborative Virtual Ward deep dive will identify areas of focus and improvement to support a consistent offer across NEL, reducing unwarranted variation.

Key programme features and milestones:

- Resident engagement across NEL by mid-2023
- Investment required to develop services and technology based platforms to meet criteria and implement the model
- Focus on patients aged 18+ in the initial roll out of this transformational programme of work. Younger population cohort to be looked at in 2023/24
- VWs will focus on ED attendance and admission avoidance but may also support reduce length of stay (LoS)
- Deep Dive into Virtual Wards by Q1 23/24 in order to address inconsistencies in offer across NEL
- We will take Q2/3 to develop the clinical model and commence recruitment and implementation to deliver the national ambition over the two years 2022/2024.
- We will explore how remote monitoring technology, existing and wider digital platforms can support to deliver VW capacity
- The current baseline trajectory for virtual wards is based on 23 beds per 100,000 population in 2022/23 and then 30 beds per 100,000 population in 2023/24. The NEL target in Q4 2023/24 is to have in place 551 virtual ward beds across the system.

Further transformation to be planned in this area:

Over the next two years

- Develop and implement a sustainable model of care for virtual wards (VW) which incorporates Multi-disciplinary team (MDT) approach
- Identify demand on workforce from VW and develop a sustainable workforce model that supports the clinical pathways as they mature
- Develop and implement a sustainable model of care for virtual wards (VW) which incorporates an Multi-disciplinary team (MDT) approach and wider community based providers
- Join the virtual wards with existing pathways to maximise admission avoidance and early supported discharge.
- As a minimum ensure we have place based virtual wards for Frailty and ARI.

Programme funding: NHSE (National Funding)

- 2022/23 - £6.412m split across 7 place-based partnerships on population health
- 2023/24 - £8.879m (funding/split tbc but similar to 22/23

Leadership and governance arrangements:

- ICB Programme delivery support
- Community Health Collaborative and Community Health Programme Board
- Virtual Ward Steering Group
- Task & Finish Groups for Clinical pathways – ARI & Frailty
- Operations Working Group – Trajectory, Capacity and Delivery Monitoring

Key delivery risks currently being mitigated:

- Interoperability of existing digital solutions in place e.g. Cerner, HIE and EMIS and functionality currently available to deliver support to VW set up
- Additional social care burden
- Workforce - recruitment, training and retention of staff
- Digital divide and inequalities
- Cross borough discharge
- Patient population and perception of VW care
- Finance and investment beyond the national funding

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention		Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Community Health Service Transformation / Community Based Care / Community Collaborative/ SRO Selina Douglas

The benefits that North East London residents will experience by April 2024 and April 2025:

April 2024:

- Residents across NEL will have a access to a consistent Virtual Ward offer regardless of where they live
- Residents across NEL will have reduced waiting times for BCYP Speech and Language Therapy
- Resident voice will be embedded in the work of the community collaborative, allowing users and their carers to shape and influence community services.
- Residents voice will influence upcoming priority areas of work and services requiring refinement.
- Mapping work will be complete allowing insights into how to enable reduction in the inequality of access or service experienced by residents across NEL

April 2025

- implement joint workDeep dives into further identified key areas undertaken with specific outcomes
- Residents benefit from improved workforce position as major community providers force strategy

How this transformation programme reduces inequalities between north east London's residents and communities:

- By Q2 23/24 delivering deep dive work into Virtual Wards, the system seeks to address the gaps in service availability between the Place-based partnerships of NEL, allowing residents access to similar service provision regardless of postcode
- By Q2 23/24 delivering deep dive work deep dive work into BCYP speech and language therapies the system addresses potential inequalities linked to waiting time variation across NEL
- By Q3 23/24 Service mapping work identifies inequality in both service availability and outcome, allowing further work to be planned addressing any arising inequality between communities (geographical or demographic)

Key programme features and milestones:

- The programme is notable for the cross-organisational engagement and decision making processes, representing a change from the traditional commissioner/provider split. The programme is owned by all members of the Collaborative.
- User and Carer Voice mechanisms are embedded through the implementation of proposals for engagement and co-production **Q2 23/24**
- Virtual Ward benchmarking is undertaken and a work programme is implemented around Virtual Wards **Q2 23/24**
- BCYP SLT benchmarking is undertaken and a work programme is implemented to improve waiting times **Q2 23/24**

Further transformation to be planned in this area:

- Over the next two years
  - ➢ Identification of further deep dives based on collaborative priorities and areas of focus as a result of mapping work
  - ➢ Development of a workforce strategy for collaborative providers
  - ➢ Embedding User Voice proposals into feedback loops and engagement mechanisms
- Over years three to five
  - ➢ To have fully embedded co-creation in service design with care providers including joint commissioning

Programme funding:

Leadership and governance arrangements:

- NEL Community Health Collaborative Sub-Committee
- NEL Community Health Collaborative Executive Oversight Group
- NEL Community Health Programme Board
- Virtual Ward Working Group
- Place-based Partnership board
- Links to BCYP Programme

Key delivery risks currently being mitigated:

- Availability of key personnel to inform transformation work at Place
- Availability of transformation resource

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health		Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention		Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Out of Hospital Unplanned Care Specialist Pathway Programme (Stroke, Neuro and EOLC) / Newham place partnerships / SRO TBC

The benefits that Newham residents will experience by April 2024 and April 2026:

- April 2024:
  - 100% of stroke patients will have access to a Stroke Early Discharge Support pathway and will have the minimum intervention of at least six weeks in line with the SSNAP standards
  - 70% of residents who experience a neurological condition will have access to a Neuro Early Discharge Support pathway and will have at least 2 weeks intervention
  - 100% of residents will have equitable access to a community stroke and neuro rehab service if required
  - 90% EOL Residents are able to die in their preferred place of death
- April 2026:
  - 100 % of residents who experience a stroke or neurological condition will have rapid access to a Stroke and Neuro Early Discharge Support (SNEDs) pathway and will have at least 6 weeks intervention
  - 80% of residents will be able to access Level 2b bed provision in North East London
  - 100% EOL residents will have a good quality of death

How this transformation programme reduces inequalities between north east London's residents and communities:

- By providing an Early Supported Discharge (ESD) service for Neuro patients leaving hospital similar to that received by stroke patients enabling equitable access for both conditions Currently there is **zero** ESD for Neuro patients
- By ensuring core principles and referral processes are aligned across all Places in North East London and that each place deliver the stroke and neuro rehab services at the **minimum** standard required
- By increasing the number of Level 2b neuro beds in NEL to reduce waiting times (currently **22%** of this cohort of patient wait more than 42 days for a bed) and the reducing the need for patient to travel out of area for this specialist service (currently **all** patients are referred out of the NEL area for level 2b bed provision)
- By ensuring that **90%** of people **with less than a year** to live are quickly identified, with Advance Care Planning conversation if required and a personalised care plans for all who needs one that are accessible to **all** system partners via the Universal Care plan System
- By providing end of life care education and training at for **all** Tier 1 participants (residents, carers and the community) and **50%** of Tier 2 participants (Providing intermediate EOLC) Tier 3 (providing advance EOLC)

Key programme features and milestones:

- Agree Model of care, including social care for the integrated stroke and neuro service – **Complete**
- Agree workforce requirements based if healthcare needs and outcomes
- Submit Integrated Stroke and Neuro Concept Paper and Business Case for approval June 2023
- Roll out the 1st phase of the integrated stroke and neuro community service changes by April 2024 (ESD and Neuro Navigator)
- Deep dive into understanding why EOLC patients are dying in hospital with specific reference to those dying with Organ Failure, Dementia and Cancer
- EOLC patient involvement Workshop to help co-design and co-produce the EOLC pathway for the population of Waltham Forest

Further transformation to be planned in this area:

- Over the next two years
  - Implement the next phase of the integrated stroke and neuro community rehab service
  - Identify estates for Level 2b neuro bed provision in NEL

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Urgent Care Working Group
- Newham End of Life Care Board

Key delivery risks currently being mitigated:

- Difficulty access social care due to workforce issues
- There is a shortage of nursing, OT, Physio and SLT Staff nationally.
- Lack of clinical lead capacity to inform discussions and make decisions going forward.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Out of Hospital Unplanned Care Specialist Pathway Programme (Stroke, Neuro and EOLC) / Tower Hamlets place partnerships / SRO TBC

The benefits that Tower Hamlets residents will experience by April 2024 and April 2026:

- April 2024:
  - 100% of stroke patients will have access to a Stroke Early Discharge Support pathway and will have the minimum intervention of at least six weeks in line with the SSNAP standards
  - 70% of residents who experience a neurological condition will have access to a Neuro Early Discharge Support pathway and will have at least 2 weeks intervention
  - 100% of residents will have equitable access to a community stroke and neuro rehab service if required
  - 90% EOL Residents are able to die in their preferred place of death
- April 2026:
  - 100 % of residents who experience a stroke or neurological condition will have rapid access to a Stroke and Neuro Early Discharge Support (SNEDs) pathway and will have at least 6 weeks intervention
  - 80% of residents will be able to access Level 2b bed provision in North East London
  - 100% EOL residents will have a good quality of death

How this transformation programme reduces inequalities between north east London's residents and communities:

- By providing an Early Supported Discharge (ESD) service for Neuro patients leaving hospital similar to that received by stroke patients enabling equitable access for both conditions Currently there is **zero** ESD for Neuro patients
- By ensuring core principles and referral processes are aligned across all Places in North East London and that each place deliver the stroke and neuro rehab services at the **minimum** standard required
- By increasing the number of Level 2b neuro beds in NEL to reduce waiting times (currently **22%** of this cohort of patient wait more than 42 days for a bed) and the reducing the need for patient to travel out of area for this specialist service (currently **all** patients are referred out of the NEL area for level 2b bed provision)
- By ensuring that **90%** of people **with less than a year** to live are quickly identified, with Advance Care Planning conversation if required and a personalised care plans for all who needs one that are accessible to **all** system partners via the Universal Care plan System
- By providing end of life care education and training at for **all** Tier 1 participants (residents, carers and the community) and **50%** of Tier 2 participants (Providing intermediate EOLC) Tier 3 (providing advance EOLC)

Key programme features and milestones:

- Agree Model of care to merge stroke and neuro community rehab service, including social care for the integrated stroke and neuro service May 2023
- Agree workforce requirements based if healthcare needs and outcomes May 2023
- Submit Integrated Stroke and Neuro Concept Paper and Business Case for approval June 2023
- Roll out the 1st phase of the integrated stroke and neuro community service changes by April 2024 (Not yet defined))
- Deep dive into understanding why EOLC patients are dying in hospital with specific reference to those dying with Organ Failure, Dementia and Cancer

Further transformation to be planned in this area:

- Over the next two years
  - Implement the next phase of the integrated stroke and neuro community rehab service
  - Identify estates for Level 2b neuro bed provision in NEL

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Tower Hamlets End of Life Care Board
- Tower Hamlets Urgent Care Working Group

Key delivery risks currently being mitigated:

- Difficulty access social care due to workforce issues
- There is a shortage of nursing, OT, Physio and SLT Staff nationally.
- Lack of clinical lead capacity to inform discussions and make decisions going forward.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Out of Hospital Unplanned Care Specialist Pathway Programme (Stroke, Neuro and EOLC) / Waltham Forest place partnerships / SRO TBC

The benefits that Waltham Forest residents will experience by April 2024 and April 2026:

- April 2024:
  - 100% of stroke patients will have access to a Stroke Early Discharge Support pathway and will have the minimum intervention of at least six weeks in line with the SSNAP standards
  - 70% of residents who experience a neurological condition will have access to a Neuro Early Discharge Support pathway and will have at least 2 weeks intervention
  - 100% of residents will have equitable access to a community stroke and neuro rehab service if required
  - 90% EOL Residents are able to die in their preferred place of death
- April 2026:
  - 100 % of residents who experience a stroke or neurological condition will have rapid access to a Stroke and Neuro Early Discharge Support (SNEDs) pathway and will have at least 6 weeks intervention
  - 80% of residents will be able to access Level 2b bed provision in North East London
  - 100% EOL residents will have a good quality of death

How this transformation programme reduces inequalities between north east London's residents and communities:

- By providing an Early Supported Discharge ESD) service for Neuro patients leaving hospital similar to that received by stroke patients enabling equitable access for both conditions Currently there is **zero** ESD for Neuro patients
- By ensuring core principles and referral processes are aligned across all Places in North East London and that each place deliver the stroke and neuro rehab services at the **minimum** standard required
- By increasing the number of Level 2b neuro beds in NEL to reduce waiting times (currently **22%** of this cohort of patient wait more than 42 days for a bed) and the reducing the need for patient to travel out of area for this specialist service (currently **all** patients are referred out of the NEL area for level 2b bed provision)
- By ensuring that **90%** of people **with less than a year** to live are quickly identified, with Advance Care Planning conversation if required and a personalised care plans for all who needs one that are accessible to **all** system partners via the Universal Care plan System
- By providing end of life care education and training at for **all** Tier 1 participants (residents, carers and the community) and **50%** of Tier 2 participants (Providing intermediate EOLC) Tier 3 (providing advance EOLC)

Key programme features and milestones:

- Agree Model of care, Activity and Workforce including social care for the integrated stroke and neuro service - **Complete**
- Submit Integrated Stroke and Neuro Concept Paper and Business Case for approval June 2023
- Identify a Provider for the Neuro Community Rehab service, mobilise and implement first by April 2024
- Deep dive into understanding why EOLC patients are dying in hospital with specific reference to those dying with Organ Failure, Dementia and Cancer
- EOLC patient involvement Workshop to help co-design and co-produce the EOLC pathway for the population of Waltham Forest

Further transformation to be planned in this area:

- Over the next two years
  - Implement the next phase of the integrated stroke and neuro community rehab service
  - Identify estates for Level 2b neuro bed provision in NEL

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Whipps Cross Catchment Area End of Life Care Programme
- Waltham Forest Urgent Care Working Group

Key delivery risks currently being mitigated:

- Difficulty access social care due to workforce issues
- There is a shortage of nursing, OT, Physio and SLT Staff nationally.
- Lack of clinical lead capacity to inform discussions and make decisions going forward.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Digital First Transformation - Primary Care/ NEL / Jo Moss, Chief Strategy & Transformation Officer, NHS NEL, johanna.moss1@nhs.net

The benefits that North East London's residents will experience over the coming year:

The Primary Care Digital First Programme oversees the effective delivery of digital transformation in north east London. In 2023/24, the programme will be in in its last operating year (year 5 of 5). The team will focus on improving patient care and experience by:

- improving digital access for patients; this encompasses remote consultation, NHS App usage, website quality (both for patients and practitioners) and e-Hubs.
- Improving practice efficiency by promoting and enabling flexible remote working and telephony
- Increasing practice staff and patient competence with regards to using digital tools through the use of digital facilitators and digital champions.

How this transformation programme reduces inequalities between North East London's residents and communities:

- The programme promotes the use technology as an enabler to ensure that all practices and PCNs have the same access to digital tools, online consultation capabilities, access and configuration through the NHS Appt. Moreover, it aims to democratise access to shared records through e-Hubs, universal online registration access, guidance on repeat prescription ordering, optimising telephony, data for demand capacity and medical record access.
- Having digital skills are essential for people's health and wellbeing and the Digital First Programme is working to tackle the 'digital divide' and reducing health inequalities in NEL via the recruitment of the Digital Champions. These champions will help patients to use technology much more effectively.

Key programme features and milestones:

- The e-Hubs programme has been set up to enable practices to; operate at scale via their PCNs; managing their online consultations together; and create a centralised model of online consultations. 26/48 PCNs have expressed interest in operating via this model and the team is working to get more PCNs signed up.
- The online and video consultation programme has been set up to help practices understand the benefits of online consultations. These benefits include: better manage demand, referral to the right clinician first time and support development of a multi-skilled workforce across the practice. For 2023/2024, the plan is to promote utilisation via comms and engagement sessions with residents.

Further transformation to be planned in this area:

- Supporting social prescribing, community pharmacy, care homes, and UEC; ensuring that all these areas are enabled to support practices as effectively as possible via digital mechanism.
- Support practice staff and clinicians to better understand demand and capacity by making use of the tools that they have available, through the NEL training hub providing a team of facilitators to support practices to adopt QI and change management methodology

Programme funding:

- Overall sum and source: £1.9 million given in 2022/2023. Expecting similar funding to 2023/2024 but this has not been confirmed by NHSE.

Leadership and governance arrangements:

- Digital First Programme updates are reported to the Digital First Board. Major risks are discussed and escalated to this forum. Exception reports are discussed at senior managers group.

Key delivery risks currently being mitigated:

- Practices across NEL may be unable to deliver online consultation access to patients in 2023/24 if the expected national online consultation license funding is not made available. This has been escalated to regional and national teams.
- Programme may not be sustainable due to lack of funding after 2023/24.

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health		Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions		Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Same day access - primary care / NEL/ SRO TBC

The benefits that north east London's residents will experiencing over the coming years up to April 2028:

- Work is underway to shape the programme and to determine quantifiable benefits to be realised by April 2028. This is likely to include benefits related to:
  - Streamlining the same day access pathway to ensure local people has access to the right service, received the right intervention in the correct setting
  - Responsive first point of contact (by phone, NHS App, NHS111 or online), enabling people to get on the right pathway
  - Ensuring everyone can access a universal service offer, no matter where in NEL you live
  - Tailored access points based on local people's needs and requirements
  - Expanding direct access and self-referrals to community services where GP intervention is not clinically necessary
  - Continue on the trajectory to deliver more appointments in general practice
  - Tailored communication and engagement with local people

How this transformation programme reduces inequalities between north east London's residents and communities:

- We aim to ensure that all our residents can achieve the same level of access to primary care, including clinical outcomes, regardless of where they live in north east London.
- This will include the delivery of equitable, high-quality services for those that require an appointment on the same day.

Key programme features and milestones:

- The programme is in its design phase and key milestones are still to be confirmed and work is underway to understand the current demand vs capacity and the levels of acuity.
- The key principle of the programme is to ensure we have a clearly defined service offer for our residents with intuitive access points and that offers residents self-care approaches, self-referral to community services or access to new, innovative services in the community
- Working with residents and clinical and operational staff, this will include a rethink of the way services for same day access operates and will require a review of the end-to-end pathway, building on the new operating model in primary care with triage as first point of contact.
- Service areas included in the scope is primary care same day access, 111 services and urgent treatment centres
- Key enablers will be available workforce, sufficient estate and digital enabled pathways
- As new models of care are being introduced, related patient education and engagement is required to guide patients to the right place.

Further transformation to be planned in this area:

- Over the next two years
  - Review of hub service, 111, GP OOH
- Over years three to five
  - Review how the programme is going and refine as needed

Programme funding:

- Relevant business cases will be developed for specific projects within the programme
- Funding source is likely to be core ICB funding

Leadership and governance arrangements:

- This programme has a system approach and interface with both the Acute Provider Collaborative and the Primary Care Collaborative
- Governance is currently being defined and will include links to the ICB UEC Board as well as the Fuller Oversight Board.

Key delivery risks currently being mitigated:

- Capacity within ICB to deliver the programme
- Capacity to deliver the services when operational (front line workforce)
- Funding in ICB for new services, including infrastructure
- Digital interoperability between providers / different access points for local people
- Management of local people's expectation
- Difficulties mobilising the programme at the pace required to maximise the transformation opportunities and align with other system requirements
- Variation of participation across NEL, dependent on stakeholder maturity and new governance arrangements in place across NEL.

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	X	Health inequalities	X	Personalised care		High-trust environment	x
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Primary care – tackling unwarranted variation, levelling up and addressing inequalities / ICB level and place level / SRO is TBC

The benefits that all NEL residents will experience by:

- April 2024:
  - All practices offering core and enhanced LTC care in NEL to minimum standards
  - Community pharmacy will offer more services – either nationally or locally commissioned
  - Improved coding in practices to help understand need and inequalities
  - Quality and performance drive on inadequate and requires-improvement CQC ratings
- April 2026:
  - All practices will be CQC rated GOOD or have action plans in place to get to them to GOOD
  - Coding in all practices is fully optimised
  - Other LIS/LESs will be able to patients through the equalisation process (subject to funding)

How this transformation programme reduces inequalities between north east London's residents and communities:

- By Apr 2024 all practices will be incentivised to deliver some level of enhanced LTC care – this addresses the ICB's commitment to level up the investment in enhanced services between boroughs
- By Apr 2024 all practices will be rated by CQC as GOOD, or have an action plan to get back to GOOD, or be offered support where the practice is rated INADEQUATE or REQUIRES IMPROVEMENT
- Better data will help understand where action needs to be taken at a place level or across NEL

Key programme features and milestones:

- LIS/LES equalisation programme
- "Clinical Effectiveness Group data LES"
- "EQUIP"'s "understanding demand" programme
- Local teams working with their practices re local variations
- Interdependencies: see primary care access, workforce and digital slides

Further transformation to be planned in this area:

- Over the next two years
  - Core and additional services in community pharmacy (eg independent prescribing for UTIs etc)
  - Dentistry (as far as NEL can effect transformation)
  - Inequalities at the borough and PCN level as opposed to across NEL
    - More equal access
    - More equal experience and outcomes
- Over years three to five TBC

Programme funding:

- Overall sum and source: TBC
- Breakdown across capital, workforce / care services, programme delivery: TBC

Leadership and governance arrangements:

- To dock-in to Fuller governance and the Primary Care Commissioning Subgroup for enhanced services and other additional investment

Key delivery risks currently being mitigated:

- Extra funding for LTC LES equalisation
- Capacity of NEL team to lead and deliver change

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Standard template: transformation in NEL

North East London Health & Care Partnership

Planned Care / Acute Provider Collaborative / SRO: Neil Ashman, Chief Executive Officer, Barts Health neil.ashman1@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Waiting times for elective care are reduced so that no one is waiting more than 52 weeks
  - Improved equity of access to diagnostic and elective care through creation of Community Diagnostic Centres in Mile End & Barking, surgical capacity at KGH and NUH and ophthalmology in Stratford
  - Reduced unwarranted variation in access to 'out of hospital' services
- April 2026:
  - Waiting times for elective care are reduced in line with national requirements moving towards a return to 18-week referral to treatment standard.

How this transformation programme reduces inequalities between north east London's residents and communities:

- By April 2024, we will have reduced the variation in waiting times that exists between acute providers for elective care
- By April 2024 we will have increased the availability of 'Advice & Refer' services via GPs to residents
- By April 2024 we will have reduced the variation in community/out of hospital service access across NEL specifically in ENT, MSK, dermatology, gynaecology & ophthalmology
- By April 2024 residents and communities able to access community diagnostic services in Barking and Mile End.

Key programme features and milestones:

The Planned Care Recovery & Transformation portfolio is designed to meet national requirements for recovering & transformation elective care services. In NEL, this will mean delivering reduction in waiting times and importantly reducing the variation in access that exists. The portfolio of work covers the elective care pathway from referral to treatment

Key milestones include:

- Development of single NEL community/out of hospital pathways
- CDCs in Barking & Mile End
- Ophthalmic outpatient/diagnostic/surgical centre-Stratford
- Additional theatre capacity in Newham, Ilford & Hackney.

Further transformation to be planned in this area:

- Over the next two years
  - Development of referral optimisation tools across NEL
  - Review for all contracts for out of hospital services
  - Increasing use of Advice & Guidance/Refer, Patient Initiated Follow-up (PIFU)
- Over years three to five
  - On-going development/implementation of transformation programmes to reduce the variation in equity of access

Programme funding:

- The programme is resourced from the ICB & acute trusts
- Theatre expansion from Targeted Investment Fund
- CDC national capital & revenue funds

Leadership and governance arrangements:

- Planned Care Recovery & Transformation Board & associated sub-committees
- APC Executive & Board
- Clinical Leadership Group in high volume surgical specialities

Key delivery risks currently being mitigated:

- Workforce –ability to recruit required workforce to fill exist -ing vacancies, creation of CDCs & expansion of theatres.
- Digital – Digital transformation linked to service transformation
- Access to transformation funding to test new care models
- Inflationary pressures on building costs

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention		Co-production		Learning system	

Standard template: transformation in NEL

North East London Health & Care Partnership

Cancer / Acute Provider Collaborative / SRO: Charles Knight, Chief executive Officer, Barts Health Charles.knight@nhs.net

The benefits that north east London residents will experience by April 2024 and April 2026:

- April 2024:
  - Access to Targeted Lung Health Check service for 40% of the eligible population
  - Access to prostate health check clinic for those with a high risk
  - Implementation of Lynch Syndrome pathways and Liver surveillance
- April 2026:
  - Earlier detection of cancer
  - Improved uptake of cancer screening
  - Every person in NEL receives personalised care and support from cancer diagnosis

How this transformation programme reduces inequalities between north east London's residents and communities:

- By March 2024 The programme will reduce health inequalities in accessing cancer screening and early diagnosis by tailoring interventions to specific audiences
- By March 2024 The programme will undertake innovative research such as the Colon Flag programme to identify patients patients who may have cancer earlier
- By March 2024 Early diagnosis work on Eastern European and Turkish populations as well as engaging with Roma and Traveller communities.
- By March 2024 Health and wellbeing information provided in various formats / languages, support for patients who do not use digital and support for people with pre-existing mental health problems

Key programme features and milestones:

The programme consists of projects to improve diagnosis, treatment and personalised care.
Key milestones to be delivered by March 2024 include:
BPTP milestones in suspected prostate, lower GI, skin and breast cancer pathways delivered

- National cancer audit implementation
- TLHCs provided in 3 boroughs with an agreed plan for expansion in 2024/25
- Cancer Alliances' psychosocial support development plan delivered
- Develop and deliver coproduced quality improvement action plans to improve experience of care.

Further transformation to be planned in this area:

- Over the next two years
  - Support the extension of the GRAIL interim implementation pilot into NEL.
  - Implement pancreatic cancer surveillance for those with inherited high risk.
  - Evaluate impact that rehabilitation interventions has on patient outcomes and efficiencies i.e. reducing length of stay and emergency admissions.
- Please note that Cancer Alliance Programme is currently funded nationally until March 2025.

Programme funding:

- *Overall sum and source: Cancer alliance funded by NHSE*

Leadership and governance arrangements:

- Programme Director Archna Mathur; Lead Femi Odewale
- Cancer board – internal assurance
- Programme Executive Board – NEL operational delivery
- APC Board and National / Regional Cancer Board

Key delivery risks currently being mitigated:

- Imaging delays in scanning and reporting (affecting backlog)
- Histopathology reporting turnaround time
- Recruitment of targeted lung health staff at Barts Health
- implementing a stratified pathway into primary care
- RMS delays at Homerton/ BHRUT are due to workforce capacity and PCC leads vacancy

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Maternity / Acute Provider Collaborative / SRO: Ralph Coulbeck, Chief Executive Officer, Bart's Health r.coulbeck@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Demand and capacity work completed which will identify the gaps between what services we currently have and what services are required to deliver high quality maternity and neonatal care to our population in an equitable way
- April 2026:
  - Have developed plans and starting to implement changes to service provision to deliver high quality, equitable maternity and neonatal care to our population
  - Identified the workforce needed to support this and starting to implement it

How this transformation programme reduces inequalities between north east London's residents and communities:

- Until the demand and capacity work is completed it is not possible to identify this however the expectation is that changes to maternity and neonatal services will reduce inequality of access and improve outcomes

Key programme features and milestones:

Aim of the workstream is to reduce inequalities and improve outcomes in maternity and neonatal services in NEL.

We will undertake demand and capacity modelling to identify how Maternity and Neonatal services need to be delivered for the current and future population of NEL. This modelling will then drive the development of a maternity and neonatal strategy for north east London and identify further priorities for the programme from April 2024 and beyond.

Further transformation to be planned in this area:

- Over the next two years
  - This will be developed based on what the demand and capacity work identifies as areas of priority
- Over years three to five
  - This will be developed based on what the demand and capacity work identifies as areas of priority

Programme funding:

- Funding is required for the demand and capacity work. There may be further funding requirements once this work is completed
- Funding for 0.5 WTE Programme Director and 1 WTE programme support

Leadership and governance arrangements:

- Programme lead: Karen Green (interim)
- A monthly Oversight group established chaired by SRO
- Reports to the APC Shadow Executive

Key delivery risks currently being mitigated:

- Funding to support the demand and capacity work which will drive the development of a maternity and neonatal strategy for north east London

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health		Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Maternity Transformation / NEL / Diane Jones, NHS NEL Chief Nursing Officer diane.jones11@nhs.net and Mark Gilbey- Cross, Director of Nursing & Safeguarding m.gilbey-cross@nhs.net

The benefits that residents will experience by April 2024 and April 2026:

April 2024:

- A reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury.
- Improved access to postnatal physiotherapy for women experiencing urinary incontinence
- Increasing breastfeeding rates across NEL especially amongst babies born to women living in the most deprived areas.
- Visible collaborative leadership maternity and neonatal leadership across NEL.
- Reduce unwanted variation in the delivery of care. (Regional Service Specification)

April 2026:

- The majority of women are offered Midwifery Continuity Care
- Maternity digital care records: Single digital system across NEL
- Improved Post Natal Care to support areas such as reduction in smoking, obesity and other public health concerns.
- Integration of Maternity and Neonatal services
- Improve interface with primary care
- Increased capacity to meet demand across NEL for birthing people

How this transformation programme reduces inequalities between north east London's residents and communities: Sup
port the alignment of demand and capacity.

- By personalised care for women with heightened risk of pre-term birth, including younger mothers and those from deprived backgrounds, we will encourage the development of specialist pre-term birth clinics across NEL
- By Maternal Medicine Networks: Ensure all women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy.
- By: Expanding access to evidence-based psychological therapies within specialist perinatal mental health across NEL LMNS
- By: ensuring all providers have full baby friendly accreditation and that support is available to those living in deprived areas who wish to breastfeed their baby

Key programme features and milestones:

- Increase access to perinatal pelvic health Services (PPHS) to ensure that all women receive information antenatally and postnatally and can be referred to PPHS up to 1yr postnatal.
- Increase Personalisation and Choice continuity of carer for BME groups and women living in the most deprived areas. (**awaiting publication of single delivery plan** trajectory)
- Saving Babies Lives Care Bundle (SBLCB) trajectory (awaiting SBLCB V3)
- To ensure that women living in deprived areas can access information and support to initiate breastfeeding
- by March 2024 every woman with medical problems has access to specialist advice and care via the NEL maternal medicine network
- Increase access to pre-term birth clinics to support every maternity service to have preterm birth clinic
- Intrauterine Transfers (IUTs) pathway working with Neonatal ODN >80%

Further transformation to be planned in this area:

Over the next two years

- 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injuries by 2025
- Midwifery Continuity Carer to be implemented when staffing levels enable MCoC to be implemented safely and to prioritise implementing the model for
- Increase support for women in post natal care

Over years three to five

Maternity digital care records: Single Digital system across NEL

Programme funding:

Regional Maternity transformation Programme funding,
ICB funding for LMNS for 3 staff.
Team, Neonatal ODN transformation funding,
Mental Health ICB funding for Perinatal Mental Health Services. HEE funding for training and education
Ockenden funding for essential quality assurance.
ICB Safeguarding and quality directorate funding.
Primary Care interface with GPs/ Health visitors.
CYP interface

Leadership and governance arrangements:

- Assistant Director of Maternity Programmes: Dawn Newman-Cooper/ Philippa Cox
- SRO (out to advert)
- NEL LMNS Chairs (3 part time)
- ICB Director of Quality/ ICB Chief Nurse (as above)

Key delivery risks currently being mitigated:

- The majority of LMNS team are seconded from Trust –risk of continuity with delivery of core LMNS functions and remit.
- Recruitment and retention of maternity workforce to delivery Midwifery Continuity of Care and other key areas.
- Integration of maternity, neonatal services into the ICB.
- Cultural and compassionate leadership within Trusts (Safety)
- Working in isolation.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Maternity Safety and Quality Assurance Programme / NEL / Diane Jones, NHS NEL Chief Nursing Officer diane.jones11@nhs.net and Mark Gilbey- Cross, Director of Nursing & Safeguarding m.gilbey-cross@nhs.net

The benefits that residents will experience from April 2024 to April 2026:

- Safe, effective maternity care by consolidating the improvement actions committed to in Better Births, the NHS Long Term Plan, the Neonatal Critical Care Review, and reports of the independent investigation at Shrewsbury and Telford Hospital NHS Trust and the independent investigation into maternity and neonatal services in East Kent and support delivery including addressing the actions highlighted in the Ockenden report.

This will be the focus of The Single Delivery Plan (SDP) published end of March 2023 which the NEL LMNS and London Neonatal ODN will be instrumental in supporting the safety improvements in Maternity and Neonatal Services.

How this transformation programme reduces inequalities between north east London's residents and communities:

- A reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury in women and babies from BME background and Women from deprived areas.
- Maternity and neonatal care are inextricably linked and work together to produce the best outcomes for women and their babies who need specialised care.
- Neonatal ODNs to work closely with NEL LMNS to ensure that high quality care is provided that is responsive to the needs of women and their babies and maintains care as close to their home as is possible.

Key programme features and milestones:

- To support Trusts in the delivery of 10 key maternity safety actions through a Clinical Negligence Scheme for Trusts (CNST).
- To support maternity and neonatal providers achieve the Ockenden Essential Actions in collaboration with the Neonatal ODN
- Support the recommendations of the Neonatal Critical Care Review
- Facilitate and support leadership cultural development outlined in the East Kent Review
- To support the recruitment, retention and well-being of maternity workforce.
- To support the training and education requirements of maternity staff in partnership with HEE.

Further transformation to be planned in this area:
Single Delivery Plan published end of March 2023 which the NEL LMNS and London Neonatal ODN will be instrumental in supporting the safety improvements to be made in Maternity and Neonatal Services.

Programme funding:
Maternity transformation Programme funding, ICB funding for LMNS Team, Neonatal ODN transformation funding, Mental Health ICB funding for Perinatal Mental Health Services. HEE funding for training and education and Ockenden funding for essential quality assurance.
Awaiting further details on funding The Single Delivery Plan for 2023/24

Leadership and governance arrangements:

- Assistant Director of Maternity Programmes
- SRO out for advert
- NEL LMNS Chairs (3 part time)
- ICB Director of Quality/ ICB Chief Nurse (interim SRO)

Key delivery risks currently being mitigated:

- The majority of LMNS team are seconded from Trust –risk of continuity with delivery of core LMNS functions and remit.
- Recruitment and retention of maternity workforce to deliver Midwifery Continuity of Care and other key areas.
- Integration of maternity, neonatal services into the ICB.
- Cultural and compassionate leadership within Trusts (Safety)
- MDT working to support to meet the needs of complex pregnant people.
- Working in isolation.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Babies, Children and Young People: Prevention Priorities: NEL BCYP SRO Diane Jones Chief Nursing Officer, NHS NEL diane.jones11@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

April 2024:

- Our children and families will benefit from accessing clinics for excess weight
- Greater signposting and access to the voluntary sector via expanded social prescribing and family support worker offer
- Good access to childhood vaccinations

April 2026:

- Children and families will benefit from integrated early help via family hubs
- Better parental and family support offer in place
- More families, particularly those at risk, benefitting from oral health support

How this transformation programme reduces inequalities between north east London's residents and communities:

We will work with place-based partnerships to baseline and reduce:

- The proportion of babies born with low birth weight in north east London (BCYP/Maternity Collaboration)
- Levels of obesity
- Levels of tooth decay

We will work with place-based partnerships to baseline and increase:

- The uptake of childhood immunisations (BCYP/Immunisation Collaboration)

Further work will be undertaken with place-based partnerships to determine outcome improvements across the other main BCYP core20plus domains (asthma, diabetes, epilepsy, mental health)

Key programme features and milestones:

- Working with key system partners through the new Joint Accountability Framework, we will lobby to increase, over time, the proportion of our budget that is spent on prevention (both primary and secondary) and earlier intervention in childhood
- Mapping current and future resource (£) available for targeted prevention projects across all places. Confirming if £ top slice to target childhood obesity is achievable; this would provide the mandate to prioritise at place and NEL.
- Map current BCYP prevention transformation projects in progress across the system.
- Agree prevention priorities for BCYP, aligned to interim strategy. Agree what is outside scope and how this is managed
- Discuss and agree the governance arrangements, roles and responsibilities leading prevention for BCYP

Further transformation to be planned in this area:

Over the next two years

- Work up priorities and implementation approach

Over years three to five

- Build prevention workforce capacity/capability

Programme funding:

- Propose a % increase on BCYP prevention spend as per strategy.
- Specific prevention funding available for primary, secondary and tertiary prevention for BCYP populations are not visible. Potentially held at local authority/place and provider level
- Breakdown across capital, workforce / care services, programme delivery is not currently available

Leadership and governance arrangements:

- We have an agreed lead DPH for BCYP (Waltham Forest DPH). We will need a facilitated discussion across Directors of Public Health to finalise our approach and agree any potential co-ordinated ICS model/collaborative working.
- Governance to be agreed across LMS and immunisations programmes for two shared priorities

Key delivery risks currently being mitigated:

- There is inequity in transformation capacity at place to deliver BCYP transformation/prevention priorities
- Current prevention priorities e.g. childhood obesity are managed at place – need to clarify governance arrangements if there is the be an aligned ICS approach

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions		Employment and workforce		Prevention	x	Co-production	x	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Babies, Children and Young People: Community Based Care: NEL BCYP SRO Diane Jones Chief Nursing Officer, NHS NEL diane.jones11@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - More home management and earlier discharge through improved access to hospital at home and enhanced community nursing services
  - More support for children and adolescents in the community, through expanded integrated care models and family hubs, and strengthened adolescent services.
  - Greater access to the voluntary sector and better signposting
- April 2026:
  - Reduction in elective waiting times for community-based care CYP services
  - A more personalised, expanded personal health budget offer
  - Continuing care assessments for all that need them in place

How this transformation programme reduces inequalities between north east London's residents and communities:

- We have reduced inequalities in service provision through benchmarking and ensuring population coverage across key service areas and standards
- A joined up approach across physical/mental health BCYP programmes maximises population health impact across BCYP populations
- Addressing wider determinants of health through developing personalised care services and interventions tailored to BCYP populations
- By implementing the Core20PLUS5 approach to reducing health inequalities for children and young people

Key programme features and milestones:

- Build upon and increase existing 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
- Developing integrated care models and pathways for children across primary secondary and community care
- Give patients and (with patient consent) carers and clinicians involved in their care, better access to their care record

Further transformation to be planned in this area:

- Over the next two years
  - Roll-out of hospital@home model
  - Integrated child health models/family hubs
  - Rolling out BCYP social prescribing across PCNs
  - Development of SCPHN workforce
- Over years three to five
  - Strengthen adolescent healthcare across all of NEL
  - Mainstreaming child health hubs/integrated models across PCNs.

Programme funding:

- System Development Funding (SDF) funding integrated child health pilots - £1287k (22/23 carry forward)
- Hospice match funding £155k 22/23 (expect same 23/24)
- Hospital at home (tbc via place leads)
- SCPHN workforce dev approx. £90k HEE funded

Leadership and governance arrangements:

- Oversight via NEL BCYP Executive Board, chaired by programme SRO
- Delivery via NEL BCYP Delivery Group, supported collaboratively by all BCYP place leads.

Key delivery risks currently being mitigated:

- Community capacity for BCYP is constrained by lack of nationally funded development programme, we are supported in NEL via our close links to our main all age CBC group.
- Our population group would benefit from a specific workforce transformation programme to support recruitment and retention – we have established a health visiting workforce programme for 23/24.

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Babies, Children and Young People: Vulnerable Groups of BCYP: NEL BCYP SRO Diane Jones Chief Nursing Officer, NHS NEL diane.jones11@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - More co-ordinated services for children with asthma, epilepsy and diabetes across acute and community settings
  - Reduced admissions for mental health, self-harm and substance abuse
- April 2026:
  - Services are high quality and personalised - children living in poverty within our communities are identified and receiving the support they need to live a healthy life including equitable access to and outcomes from our services
  - Children with SEND and their families receiving earlier diagnosis and benefiting from more support pathways

How this transformation programme reduces inequalities between north east London's residents and communities:

- We have reduced inequalities in service provision through benchmarking and ensuring population coverage across key service areas and standards
- A joined up approach across physical/mental health BCYP programmes maximises population health impact across BCYP populations
- Addressing wider determinants of health through developing personalised care services and interventions tailored to BCYP populations
- By implementing the Core20PLUS5 approach to reducing health inequalities for children and young people

Key programme features and milestones:

- Collaboration 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 disabilities.
- Improving the experience and support available for all children as they transition to adult services
- Improving access to children and young people's emotional health and mental health services
- Increasing access to prevention and self-management for children and young people with diabetes
- Increasing access to specialist epilepsy support for children including those with learning disabilities and autism
- Improved earlier diagnosis and support pathways for children and SEND and their families

Further transformation to be planned in this area:

- Over the next two years
  - Identify further collaboration opportunities between education, health and social care to ensure school readiness for all children and to meet the needs of children with SEND, autism and complex medical issues
- Over years three to five
  - Develop strategic approach across all BCYP long-term condition pathways

Programme funding:

- NHSE funded pilots –asthma practitioners , diabetes complications of excess weight clinics and improving access to diabetes technology 2022/23 £160,425k , 23/24-£163,38, 2024/25-£86k,

Leadership and governance arrangements:

- Oversight via NEL BCYP Executive Board, chaired by programme SRO
- Delivery via NEL BCYP Delivery Group, supported collaboratively by all BCYP place leads.

Key delivery risks currently being mitigated:

- There is a need to develop the infrastructure for epilepsy and diabetes in line with the model in place for asthma.
- Workforce capacity and development is especially acute within SEND health services at Place

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	
Long-term conditions	x	Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Babies, Children and Young People Programme: Community-based care / Place / Kath Evans, Director of Children's Nursing, Bart's Health & Mark Scott, Programme Director, NHS NEL - markscott3@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

April 2024:
- Improved access to community-based services when babies, children and young people need them
- Reduced number of unplanned admissions to hospital
- Improved waiting times for BCYP Speech and Language Therapies via the Community Health Collaborative Deep Dive

April 2026:
- Reduction in waiting times for community-based care CYP services (less than 52 weeks)
- Community-based care services are high quality and personalised (Outcomes framework)
- Continuing care assessments for all that need them in place (using data to support this)

How this transformation programme reduces inequalities between north east London's residents and communities:
- By focusing on physical and mental health outcomes
- By working across the entire BCYP population of north east London and knowing the data using Community Dashboard (in-development) will be used to track our numbers
- By focusing on the wider determinants of health
- By implementing the Core20PLUS5 approach to reducing health inequalities for children and young people

Key programme features and milestones:

Build upon and increase existing 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

- Developing integrated care models and pathways for children across primary secondary and community care
- Give patients and (with patient consent) carers and clinicians involved in their care, better access to their care record
- Community Collaborative BCYP SLT deep dive benchmarking complete **Q2 23/24**

Further transformation to be planned in this area:
- Over the next two years
  - Roll-out of hospital@home model
  - Place Integrated child health models/family hubs
  - Build on social prescribing workstream
  - Development of SCPHN workforce
- Over years three to five
  - Build community capacity further with new models
  - Strengthen adolescent healthcare

Leadership and governance arrangements:
- NEL BCYP Executive Board & Community Health Programme Board
- NEL BCYP Delivery Group
- NEL ICB BCYP Delivery Leads
- NEL ICS Place based delivery leads

Programme funding:
- System Development Funding (SDF) funding integrated child health pilots - £1287k (22/23 carry forward)
- Hospice match funding £155k 22/23 (expect same 23/24)
- Hospital at home- we will need to get this from Local leads,
- SCPHN workforce dev approx. £90k HEE funded

Key delivery risks currently being mitigated:
- Capacity
- Funding
- Workforce transformation development

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Best chances for babies, children and young People/ Barking and Dagenham Place / Sharon Morrow, Director of Partnership, Impact & Delivery Barking and Dagenham, NHS NEL sharon.morrow2@nhs.net

The benefits that Barking & Dagenham residents will experience by April 2024 and April 2028:

- April 2024:
  - Investment for essential services in the crucial Start for Life 1001 days (from conception to age two)
  - Setting up 3 locality based family hubs as the focus for integrated working across the system and family hub networks in the borough
  - Setting up acute paediatric care to a range of patients and families in the community and home-H@H
  - Establish a comprehensive children' community care model across BHR integrating the current community nursing (CCN), special school nursing (SSN), continuing care (CC) and various Clinical Nurse Specialist (CNS) teams into 3 pathway teams-PINS
- April 2028:
  - Working collaboratively so that every baby, child, young person and their family gets the best start, is heathy, happy and achieves, thrives in inclusive schools and settings, in inclusive communities, are safe and secure, free from neglect, harm and exploitation, and grow up to be successful young adults.
  - Integrated family support services from pre birth through to early adulthood in their locality
  - Families only having to tell their story once and seamless pathways to the right support at the right time – focus on prevention and early intervention (including wider determinants of health such as debt, housing, employment)
  - Personalised care co-developed with them to ensure needs are met.
  - A better offer for those with social, emotional and mental health needs

How this transformation programme reduces inequalities between north east London's residents and communities:

- By improving integration of services to provide seamless support, increasing access to services closer to their home and by ensuring services meet their specific needs far more closely through a whole family, personalised approach.
- By addressing inequalities of access to services by working with our seldom heard communities to improve the offer and make services more accessible, acceptable and effective.
- By improving quality, access and support for children and young people with SEND to reduce inequalities with their peers and ensure that they are valued, visible and included in their local communities.
- By improving equity, quality, access and impact of maternity and health visiting services including continuity or care, better rates of breast feeding, improved perinatal mental health, immunisation and two year old check

Key programme features and milestones:

- 2 Family Hubs live by end June 2023, third live by end December 2023.
- Full programme of Start for Life services delivering by October 2023 – including infant feeding, parental mental health, and parenting.
- Engagement with families via parent carer panels and family feedback – constant service improvement to respond to feedback / needs.
- Redesign of the 0-19 healthy child programme service to better align to needs in the borough, focusing on prevention and early intervention, with better links to support services and Start for Life / Family hub services (go live April 2024)
- School nursing (PH and specialist) service work to ensure all children with SEND needs have access to appropriate provision.
- LMNS equity and equality work
- Within the PINS model Hospital at Home (H@H) will be a 'stand-alone' team (although fully integrated within the wider PINS team) able to provide acute paediatric care to a range of patients and families in the community and home.
- Recruit H@H Team and launch service (Q1 23/24)
- Extend the service to GPs and permit direct referral into the H@H service (Q4 24/25)

Further transformation to be planned in this area:

- Over the next two years
  - Create a subsidiary pathway for management of certain cohorts of children referred to the ophthalmology department at BHRUT, by qualified community optometrists.
  - Further needs assessment and targeting of 0-5 services to ensure vulnerable groups access effective services earlier and don't escalate.
  - Improvement of infant feeding journey from pre-birth to 2.
  - Improvement in the offer for those with social, emotional and mental health needs
- Over years three to five
  - Evaluate Start for Life / Family hubs services and build them into business as usual where indicated

Programme funding:

- Overall sum and source: (£3,781,332 - Start for Life and Family Hubs programme funding until March 2025)
- NEL ICB

Leadership and governance arrangements:

- Best Chance for Children and Young People 0-25 partnership
- Barking & Dagenham Partnership Board
- Early Help Transformation programme board

Key delivery risks currently being mitigated:

- Difficulty recruiting experienced children's nurses reducing delivery of phased targets mitigated by use of BHRUT recruitment initiatives and current staff opportunities.
- Short timescales from DfE for start for life / family hubs
- Insufficient funding for Start for Life / Family hubs full offer – service reconfiguration and input from all partners required
- Insufficient specialist school nursing capacity impacting on public health school nursing service for mainstream schools
- Increasing number of children and young people with SEND and associated EHCPs – need and demand is increasing faster than budgets and service capacity

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Children Young People Maternity and Families / City and Hackney / [Jacquie Burke jacquie.burke@hackney.gov.uk]

The benefits that City and Hackney residents will experience by April 2024 and April 2026:

- April 2024:
  - Wellbeing and Mental Health support (WAMHS) in all schools
  - Social prescribing and key worker offers to support early help and system navigation
  - Accessible information for families about support across the system including transitions and Autism
- April 2026:
  - CYP and families can access integrated early help and a pathway of support from antenatal /pre-diagnosis through to transition to adulthood
  - .Families feel the impact of our anti-racist approach and focus on the needs of the child, with education health and care working together in the locality

How this transformation programme reduces inequalities between north east London's residents and communities:

- CYP with emotional health and wellbeing needs receive early help to maintain school engagement, pre- diagnosis support based on need, with fewer CYP requiring unplanned admissions.
- Embedding of SEND joint commissioning across education, health and care means there is equal access to high quality provision. Robust needs assessment, demand and capacity planning, workforce innovation, co-production with CYP and families, our offer will respond to the needs of our communities; with a focus on access for specific groups such as those attending independent schools. Safeguarding at Place supports our focus on reducing inequalities for our Looked After Children and
- Our anti-racism work includes bespoke maternity offers for black and global majority women, intersectionality with SEND, school exclusions and youth justice recognising the poorer outcomes for these cohorts

Key programme features and milestones:

- 2022-25 Hackney SEND action plan with SEND Inspections in City and Hackney expected early 2023
- Development of Family Hubs and Super Youth Hub/s 2023-2025 to bring services together to create a safe and accessible space for families
- Hackney's STAR (Systemic, Trauma Informed and Anti-Racism) approach will be visible, with long term commitment to transform how we engage and work with families
- Public Health recommissioning of CYP services 0-19 (25 with SEND) 2022-2024 conducted in partnership with health, care, education stakeholders and community insight

Further transformation to be planned in this area:

- Over the next two years
  - Increasing MDT working and integrated service configuration at neighbourhood level
  - Co-production is embedded and is BAU across the portfolio
  - NEL SEND governance and NEL wide risks such as workforce planning are addressed

  Over the next 3-5 years

  There is consistency of quality and standards across NEL w

Programme funding:

- Keyworker and social prescribing funding non recurrent c. £400k in total across 2 years from ICB / LDA

Leadership and governance arrangements:

- CYPMF Health and Wellbeing Strategic Partnership
- CYPMF Emotional Health and Wellbeing Partnership
- City of London SEND Programme Board and Hackney SEND Partnership Board

Key delivery risks currently being mitigated:

- Demand and capacity across specific services including CAMHS and audiology
- Staff recruitment challenges across specific services and recognition of urgent risks across NEL
- LA pressures including SEND system and high cost packages of care (SEND estates strategy and developing joint funding arrangements in train)

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Children Young People Maternity and Families Childhood Immunisations / City and Hackney / [Jacquie Burke jacquie.burke@hackney.gov.uk]

The benefits that City and Hackney residents will experience by April 2024 and April 2026:

- April 2024:
  - ➢ All families will have good access to all childhood vaccinations
- April 2026:
  - ➢ The risk of disease outbreak will be reducing
  - ➢ Families will have established and accessible information and spaces in which to discuss vaccine hesitancy

How this transformation programme reduces inequalities between north east London's residents and communities:

- City and Hackney has the lowest childhood immunisations (0-5 years) in NEL, with historically low coverage in NE Hackney and a measles outbreak in 2018
- This programme builds on the local investment, enhanced capacity and call and recall, and community engagement delivered by Partners since 2017, refreshing our Strategy, taking a QI approach to work with practices, establishing a baseline of vaccine hesitancy insight and delivering targeted engagement work to mitigate this, and embedding PCN led sustainable delivery that was tested during the Polio response
- This is a longer than 5 year transformation programme, recognising the cultural change that is required to achieve and sustain change in immunisation take up

Key programme features and milestones:

- 18 month Childhood Imms Programme Manager recruited March 23 to co-produce refreshed strategy with Partners and support operational improvements
- ICB non-recurrent investment in NE Hackney continues to ensure targeted offer to Charedi community who generally vaccinate late outside of the schedule and require bespoke comms and Sunday clinics
- NHSE funded Imms Coordinator (delivers targeted engagement to NE Hackney) ends March 24; evaluation of role to inform future arrangements
- Local voluntary and community leaders' leadership to be sustained and strategy to include development of immunisations champions

Further transformation to be planned in this area:

- Over the next two years
  - ➢ The refreshed strategy will include trajectories for improvement, noting success was measured as a 2% increase in NW Hackney via targeted call and recall during an NHSE funded 1 year pilot pre Covid

Over the next 3-5 years

- ➢ There is an increase in the number of PCNs achieving herd immunity and an increase of c.10% across NE Hackney

Programme funding:

- ➢ Inequalities funding
- ➢ NHSE immunisations coordinator funding 0.5 wte for Year 2 March 23-March 24

Leadership and governance arrangements:

- CYPMF Health and Wellbeing Strategic Partnership
- C&H Immunisations and Vaccinations Steering group
- C&H Public Health led all CYP immunisations working group

Key delivery risks currently being mitigated:

- No recurrent ICB funding in context of changing commissioning responsibilities
- Pressures in primary care which are exacerbated for practices with large child lists which in C&H are broadly those with high vaccine hesitancy
- Requires intensive and ongoing engagement and comms work
- Requires intensive and ongoing call and recall support for practices, learning from Covid informs current centralised approach
- Nurse capacity – bank of Nurses established in C&H to support across primary care

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health		Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions		Employment and workforce		Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Starting well programme / Havering / Luke Burton, Borough Director, luke.burton1@nhs

The benefits that Barking and Dagenham, Havering and Redbridge residents will experience by April 2024 and April 2026:

- April 2024:
  - Children aged 5 to 11 that are an unhealthy weight will have access to a **new childrens weight management service**.
- April 2026:
  - Children with complex needs who require support from multiple services will benefit from a **joined up Multidisciplinary approach** to their care, supported by **PCN based teams** comprised of primary care, social care, care sector and VCSE leads to produce a **single care plan, co designed** with the child and their family around the outcomes that they want to achieve. These teams will work in a proactive way, using data to identify those most in need.

How this transformation programme reduces inequalities between north east London's residents and communities:

- By launching a childrens weight management service which is targeted at the three most deprived parts of Havering this will help reduce inequalities as childhood obesity is more prevalent in the most deprived parts of the borough

Key programme features and milestones:

- Recruit childrens weight management service coordinator by January 2023
- Launch children and young people weight management service by April 2023

Further transformation to be planned in this area:

- Over the next two years
  - Expand the childrens weight management service to be located across broader footprints in Havering

Programme funding:

- Childrens and young peoples weight management service (£50k from Health Inequalities and LBH match funding)
- £150k from 23/24 place allocations for Integrated MDT

Leadership and governance arrangements:

- Children, Babies and Young People Group, reporting into the Havering Place based Partnership Board

Key delivery risks currently being mitigated:

- BCYP weight management service - Lack of engagement from families with children that are an unhealthy weight
- Finance - Uncertainty about future years funding arrangements
- Workforce - Restructuring to both London Borough of Havering and ICB staff that are delivering the project management for the Health Inequalities Programme and childrens weight management service.

Alignment to the integrated care strategy:									
Babies, children, and young people	X	Mental health		Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

BHR Autism (ASD) Programme / BHR place partnerships / SRO Sharon Morrow

The benefits that Barking and Dagenham, Havering and Redbridge residents will experience by April 2024 and April 2026:

ASD - by April 2024:

- A dedicated hub and spoke ASD service delivering best practice diagnosis and both pre and post diagnosis support for children and families
- An expanded supernumerary clinical and support ASD team working to eliminate backlogs and deliver defined diagnosis and follow up waiting times
- A single point of access to the dedicated Autism team including SALT, Psychologists and Paediatricians
- Elimination of area variance through the establishment of SOP for referral, screening, needs-based support
- Best practice transition arrangements with additional specific criteria to manage 18–25-year-olds
- Elimination of clinical backlogs and the release of existing CAMHS resources into EWMHS provision
- Wider integrated LDA provisions within Primary Care and secondary care with MDT provisions and sensory adjustments

ASD – by April 2026:

- A dedicated clinical workforce able to fully meet the needs of the service users
- Referral to ASD diagnostic assessment waiting time of 13 weeks;
- Waiting time to follow up appointment following ASD diagnostic assessment of 6 weeks
- A fully NICE compliant ASD service
- Meeting the strategic objectives of the roadmap for the national 5-year strategy for autistic children and young people and complying with the Autism Act 2009.

How this transformation programme reduces inequalities between north east London's residents and communities:

- Facilitation of timely diagnosis families with Autistic children supporting integrated system responses to vulnerable LDA service users
- Pre and post diagnosis support (including 3rd sector) for families with vulnerable children with cultural adjustments to reflect inequity of current provisions
- Cultural adjusted and targeted health promotion & training in the community with education & training strategies to enable self-management for patients and families
- Support within the wider SEND structures for those CYP with additional and complex needs including sensory adjustments in BCYP service provision

Key programme features and milestones:

- Soft ' launch January 2023 – all new referrals where ASD is suspected will be managed in the new ASD pathway team. Existing patients are still with locality teams but further integration is part of the whole transformation programme.
- Referral routes don't change as the locality hubs across BHR will process all referrals as usual and ensure that the new ASD service receive the referral. Patients will be seen in local venues to them across BHR so provision will work on a hub and spoke model
- Aim to deliver NICE concordant offer in a more timely way

Further transformation to be planned in this area:

- Over the next two years
  - An on-going programme to deliver expanded ASD provisions aligned with Phase funding

Programme funding:

- Phase 1 funding confirmed
- Funding for subsequent Phase roll out within system

Leadership and governance arrangements:

- Multi-agency working group
- CYP Transformation Board, NEL BCYP delivery Board
- Area based PbP

Key delivery risks currently being mitigated:

- Follow up Phase funding issues present a significant risk to the delivery of the full NICE compliant provision
- Recruitment is a risk so we established links to new Clinical and Professional Leads and working in partnership with Professor Baron Cohen and the team at Cambridge University

Alignment to the integrated care strategy:

Bal	Babies, children, and young people	✓	Mental health	✓	Health inequalities	✓	Personalised care	✓	High-trust environment	
Lor	Long-term conditions	✓	Employment and workforce		Prevention	✓	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

BHR Paediatric Integrated Nursing Service (PINS) SRO Tracy Rubery

The benefits that Barking and Dagenham, Havering and Redbridge residents will experience by April 2024 a
PINS - by April 2024:

- Establishment of major components within a community nursing services for children delivering care within a best practice integrated model including LTC management, complex and continuing care, continence and EOLC
- Parents attending ED to be offered support within community provision and alternative discharge options to acute observation
- An integrated Health / Social Care and 3rd sector service mirroring NWL Connecting Care for Children and centred around an MDT 'Hub' and providing holistic support for family needs
- Complex children and their families to be receiving continuity of care through a model of provision spanning the home and education environments

PINS – by April 2026:

- Full alternative ED referral route into an integrated community provision (Hospital @ Home)
- Vulnerable children cared for within an holistic complex pathway model across both home and school
- Children with level 2 continence needs have fast access to specialised support in the community
- BCYP with LTC supported by dedicated CNS working within an integrated support system
- Specialist EOLC available within wrap around service provision

How this transformation programme reduces inequalities between north east London's residents and communities:

- The integrated provisions address the social determinants of health
- Complex pathway children are the most vulnerable and disadvantaged in society
- Significant % of the relevant cohorts have LDA needs
- The CC4C model targets families in greatest need
- Asthma, allergy and sickle cell are over represented within disadvantaged groups

Key programme features and milestones:

- Hospital @ Home live from April 2023
- Common CCNT model established within 2023/24
- Best practice continence service awaiting funding 2023/24
- CC4C 'Hubs' operational by Q2 2023/24
- EOLC model in place
- Complex Pathway model multi agency sign off within 2023/24

Further transformation to be planned in this area:

- Over the next two years
  - Further improvements in integrated provision
  - Further improvements targeted provisions

Programme funding:

- Funding for Hospital @ Home agreed
- Funding for expanded continence provision awaiting confirmation
- EOLC funding agreed

Leadership and governance arrangements:

- Multi Agency working groups delivering models
- Redbridge PBP is lead for the PINS programme
- Revised ToR and membership for Complex Pathway

Key delivery risks currently being mitigated:

- Investment delay is a significant risk to the delivery of these integrated services seeking to reduce pressures on primary and acute care
- Complex pathway requires political management due to multi-

Alignment to the integrated care strategy

Bal	Babies, children, and young people	✓	Mental health		Health inequalities	✓	Personalised care	✓	High-trust environment	✓
Lon	Long-term conditions	✓	Employment and workforce		Prevention	✓	Co-production	✓	Learning system	✓

Transformation in NEL

North East London Health & Care Partnership

Babies, Children and Young People / Newham Place-Based Partnership / Sarah Wilson, Director of Specialist Services (Children's), ELFT sarah.wilson48@nhs.net and Tim Aldridge, Director of Children's Services, LBN Tim.Aldridge@newham.gov.uk

The benefits that Newham's residents will experience by April 2024 and April 2026:

- April 2024:
  - Improved access to community-based services when babies, children and young people need them
  - Access to more integrated services in one place
  - Improved SEND provision and outcomes

How this transformation programme reduces inequalities between north east London's residents and communities:

- By identifying and agreeing priorities that are locally focussed based on data and evidence
- By focussing on universal to specialist level of needs using population health management approaches
- By having a strengthened focus on equity, equality and challenging racism and all forms of discrimination
- By working with and across all system partners, with a strengthened focus on residents voice from the start of any project

Key programme features and milestones:

- April 2023 – Agree a small number of initial priorities for partners to work together to deliver better outcomes for residents, staff and the system
- Speech and language therapy
- Roll out family hubs with a range of integrated services
- Improve outcomes for women, birth people and babies with a focus on inequities
- Develop our MH offer including for those with the most complex needs
- Integrate care across primary, community and secondary care with a focus on LTCs, MDTs and our youth zone offer
- Continued improvement of the SEND support offer

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Babies, Children and Young People Joint Planning Group chaired by the SROs, which reports up to the Newham Health and Care Partnership Board and NEL BCYP Joint Committee

Key delivery risks currently being mitigated:

- X
- X

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Pan BHR SEND Therapy Provision SRO Sharon Morrow

The benefits that Barking and Dagenham, Havering and Redbridge residents will experience by April 2024 and April 2026:

SEND Therapy Provision - by April 2024:

- Pupils in identified special schools will have their AHP needs met though a new model of joint working between Health and Education with increases in therapy provision and reductions in wait times
- Outcomes from Workforce Academy programmes should deliver additional AHPS and shorten wait times
- Outcomes from Workforce Academy programmes should deliver additional AHPS and allow greater use of tailored inputs

SEND Therapy Provision – by April 2026:

- Workforce Academy planning will increase the availability of timely therapy intervention
- Integrated Phase 2 ASD programme roll out will be bringing an integrated model of working to vulnerable service users to assist them and their families both pre and post diagnosis

How this transformation programme reduces inequalities between north east London's residents and communities:

- CYP needing SEND therapies are amongst the most vulnerable in society
- There is a strong correlation between SEND needs (especially SALT) and social deprivation
- Early and appropriate interventions positively affect lifelong levels of achievement

Key programme features and milestones:

- Pan NEL adoption of the Workforce Academy programme Q1 2023/24
- Outcomes from Astrum Pilot demonstrating revised model of working Q2/3 2023/24
- Parity AHP business cases emerging from SEND baseline workstream and community collaborative inputs Q1 2023/24
- Significant issues remain with parity and capacity of CYP AHP provision across BHR Boroughs

Further transformation to be planned in this area:

- Over the next 2 years significant investment needed to meet the pressures identified in the multi-agency SEND baseline review
- Outcomes and KLOES from Joint OFSTED/CQC area inspections

Programme funding:

- TBC in support of Joint area inspection outcomes and parity business cases

Leadership and governance arrangements:

- Workforce Academy pan NEL with AHP workstream lead by Havering PBP Director
- Actions and governance primarily via PBP and SEND Executives

Key delivery risks currently being mitigated:

- Major risk is arising from recruitment and retention issues in NEL leading to wage inflation and INEL resource 'capture'
- Workforce Academy programme working to close Recruitment &Retention gap through revised methods of working

Alignment to the integrated care strategy:

Babies, children, and young people	✓	Mental health		Health inequalities	✓	Personalised care	✓	High-trust environment	✓
Long-term conditions	✓	Employment and workforce		Prevention	✓	Co-production	✓	Learning system	✓

Transformation in NEL

North East London Health & Care Partnership

BHR Tier 3 NICE compliant Paediatric Obesity Service SRO Sharon Morrow

The benefits that Barking and Dagenham, Havering and Redbridge residents will experience by April 2024 and April 2026:
Paeds Obesity Service - by April 2024:

- Establishment of NICE compliant obesity Tier 3 provision taking learning from Complication from Excess Weight Clinics (CEWS)' pilot schemes
- A multi-disciplinary team utilising dietitians, psychologists, family therapists, exercise support worker, physicians and other experts to develop a tailored/individualised care plan.
- Reductions in immediate and lifelong health and emotional issues through early systemic intervention
- Specific reductions in LTC such as diabetes

Paeds Obesity Service – by April 2026:

- A fully integrated multi-agency weight management service covering Tiers 1-4

How this transformation programme reduces inequalities between north east London's residents and communities:

- Reduced inequalities across our population due to higher rates in CYP living in economically deprived areas, those of certain ethnic minority heritages and girls
- Early intervention reducing lifetime health and EWMH issues within those identified as having inequity of opportunity and outcomes

Key programme features and milestones:

- Further modelling to be undertaken to identify activity and forecast demand for service
- Development of comprehensive multi-agency service specification
- Submission of robust business case
- Securement of initial investment

Further transformation to be planned in this area:

- Over the next two years
  - Investment permits the roll out of the comprehensive multi-agency model as part of a best practice Tier 1-4 system

Programme funding:

- TBC

Leadership and governance arrangements:

- The T3 WMS via BHR HCC through the overarching BHR Obesity action Plan. The T3 WMS forms one action as part of 14 strong action plan on obesity. Subject to governance revision

Key delivery risks currently being mitigated:

- There are no T3 Paediatric WMS service at present and so the identified risks and consequences include continuing to provide inadequate WMS not meeting NICE quality standards, levels of obesity will continue to worsen

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Born Well, Grow Well / Tower Hamlets / Warwick Tomsett, Borough Director Tower Hamlets, NHS NEL Warwick.Tomsett@towerhamlets.gov.uk

The benefits that Tower Hamlets residents will experience by April 2024:

- Enhanced access to, and experience of, mental health services for children and young people
- Improved SEND provision and outcomes
- Fewer children and young people that are obese or overweight
- Access to more integrated services in one place, starting with Early Help provision
- Support for families to mitigate the impact of the cost of living crisis

How this transformation programme reduces inequalities between north east London's residents and communities:

- By addressing inequalities that exist in provision of mental health services, ensuring that any gaps in outcomes for children and young people from different backgrounds are addressed
- By mitigating the impact of the **cost of living crisis** on more **deprived families**
- By ensuring that those with SEND are able to access the services they need and are assisted to achieve their potential
- By addressing inequalities that are causing higher obesity levels in children and young people from certain backgrounds more than others, using a targeted approach where required

Key programme features and milestones:

- Mental health services: A programme with 17 projects has been developed for delivery which includes: Tower Hamlets Education Wellbeing Service, CAMHS personal health budgets, extended Crisis hours, an eating disorder service, support for sexual abuse victims.
- Improved SEND provision focuses on: leading SEND, early identification and assessment, commissioning effective services, good quality education provision & supporting successful transitions.
- Tackling childhood obesity has 3 focus areas: healthy places, healthy settings, healthy services.
- More integrated services plans to start with the ambition of creating an effective Early Help Eco system with a common practice approach

Further transformation to be planned in this area:

- Over the next two years
  - Development of existing key programmes to be determined in the next 2 years
  - Programme mapping – to identify gaps in integration

Over years three to five

- Transformation plans to be confirmed i.e. phasing, scope and milestones

Programme funding:

- Core based budgets from LBTH and ICB
- Health Inequalities funding
- Public Health
- Mental Health Investment Standards

Leadership and governance arrangements:

- Principal strategic and operational oversight by Children and Families Executive Board
- Monthly delivery oversight by Local Delivery Board
- Quarterly assurance monitoring at THT Executive Board

Key delivery risks currently being mitigated:

- Project management support
- Gap in data and data insights

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

BCYP / Waltham Forest / Sue Boon, Director of Partnership, Impact & Delivery Waltham Forest, NHS NEL, sue.boon@nelft.nhs.uk

The benefits that Waltham Forest residents will experience by April 2024 and April 2026:

- April 2024:
  - Have an agreed joint partnership strategy for BCYP
  - Improved knowledge and access to health services, reducing the number of frequent attenders at ED
  - Improved support for BCYP presenting at ED with asthma
  - Hospital @ Home will improve outcomes for BCYP with health needs
- April 2026:
  - Residents will experience joined up working between BCYP services across Waltham Forest
  - Increased access to mental health support at an early intervention/prevention stage in the community

How this transformation programme reduces inequalities between north east London's residents and communities:

- By linking with the evidence and action plan of the Marmot Review
- By identifying the reasons for people frequently attending ED, and supporting identified inequalities in accessing services
- By developing the BCYP strategy, we will include health inequalities and identify actions to reduce health inequalities
- By increasing early intervention opportunities and community MH services for cyp, we will reduce inequalities in access

Key programme features and milestones:

- BCYP strategy – by summer 2023
- Implementation of Frequent Attender project
- Business Case for 48 hour reviews for asthma
- Implementation and evaluation of H@H service

Further transformation to be planned in this area:

- Over the next two years
  - Improved access for CYP with LD in primary care and acute setting
  - MDTs in primary care for CYP
- Over years three to five
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- BCYP Executive Group – sub group of place based partnership board
- X

Key delivery risks currently being mitigated:

- Workforce – issues in both MH and Primary Care
- Increased demand and acuity for services
- Ability to invest long term in areas that will reduce inequality whilst still trying to meet acute demand
- BCYP often get 'lost' in all age programmes, resulting in

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

2. Additional local strategic priorities

Transformation in NEL

North East London Health & Care Partnership

Cardiovascular Disease / NEL / SRO: Charlotte Stone, programme Director, NHS NEL -charlotte.stone14@nhs.net

The benefits that NEL residents will experience by April 2024 and 2029:

By 2024

- Cardiac Rehabilitation – by 2024 all eligible residents across NEL will have equitable access to Cardiac Rehabilitation services (Whipps Cross service to go live by 2024), and to ensure high quality services across all areas (pathway to green certification across all services)
- Improved for Lipid Management across NEL – delivered by targeted projects in Waltham Forest and Barking & Dagenham and Newham (targeted health inequalities projects).
- Improved uptake of BP monitoring delivered via BP@Home
- Improved BP detection - via community pharmacy services and improved uptake of NHS Health Checks.
- Improved Heart Failure services – reviewing and developing a plan to action the recommendations of the audits conducted by the North London Cardiac Delivery Network and to ensure accessible and high quality services.
- Improved outcomes relating to CVD risk factors eg Lipids and hypertension – via LTC outcomes framework

By 2029

- Improve detection of atrial fibrillation and ensure appropriate stroke risk reduction through anticoagulation - by 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation.
- Improve detection of undiagnosed hypertension and ensure those with hypertension are controlled to target – by 2029 80% of expected numbers with hypertension are detected and 80% of people with high blood pressure are treated to target
- Improve the numbers of people who have had a CVD risk assessment and cholesterol check – by 2029 75% of people eligible have had a CVD risk assessment and cholesterol reading recorded on primary care data system in last 5 years
- Ensure patients who have a history of CVD are on optimal lipid lowering therapy and improve detection of Familial Hypercholesterolaemia (FH) – by 2029 45% of people aged 40-74 identified as having 20% or greater 10 year risk of developing CVD in primary care are treated with statins and 25% with FH are diagnosed and treated optimally.
- Improve access to and uptake of Cardiac Rehabilitation (CR) – by 2029 85% of eligible patients are accessing CR
- Improve diagnosis of Heart Failure (HF) and optimal management of patients with HF - 90% of people with HF will have an annual review

How this transformation programme reduces inequalities between north east London's residents and communities:

- By taking a population health approach and using insights and data to inform priorities, target inequalities and variation
- Targeting specific underserved populations in Barking & Dagenham and Newham with initiatives to increase the number of residents having CVD risk factors checks and improve the uptake of innovative lipid lowering therapies to minimise the risk of myocardial infarction and stroke
- Targeting specific underserved populations in Waltham Forest via delivery of initiatives to improve detection and optimisation of lipid management to minimise the risk of myocardial infarction and stroke
- Utilising Health Inequalities audit data to plan and develop Cardiac Rehabilitation services to improve uptake and completion of cardiac rehabilitation services
- Improving uptake of BP monitoring initiative in underserved populations – BP@Home champions

Key programme features and milestones:

- Establishing formal governance and programme infrastructure required to deliver this programme of work.
  - Formalise the cardiology relationship via structures agreed on 20.1.23 (Q4 22/23)
  - Develop a jointly-owned vascular and CVD plan (Q1 23/24
  - Develop a NEL CVD Strategy (Q2 23/24)
  - Establish governance for the working groups (Q4 23/24)
  - Set up working groups (Heart Failure, Hypertension Lipid Management, Atrial Fibrillation) (Q1 23/24)
- Agree pathway and innovations for the CVD Health Inequalities project (InHIP) (B&D and N) (Q4 22/23)
- Delivery of the InHIP project (Q1 –Q4323/24)
- Completion of the InHIP project (Q4 23/34)
- Roll out of the LTC outcomes framework (Q2 23/24) (led contractually by primary care) – impacting on benefits
- Increase in capacity of Cardiac Rehabilitation at Whipps Cross Hospital (Q1 23/24)
- Business case development for recurrent funding of Whipps Cross Cardiac Rehabilitation Services (date tbc)
- Optimisation of Lipid Management STF Project in Waltham Forest – initiation of project (Q1 23/24), Delivery of project (Q2 – Q4 23/24)
- Completion of Optimisation of Lipid Management STF project (Q4 23/24)

Further transformation to be planned in this area:

Over the next two to five years

- Development of CVD dashboards that provide actionable insights
- Scoping opportunities for standardising access and delivering care
- Business case to secure recurrent funding for Cardiac Rehab at Whipps Cross

Programme funding:

- SDF funding
- InHIP £100k,
- Whipps Cross £365k,
- STF project £134,250
- CVD Prevention Leadership £117k
- Local place transformation funding

Leadership and governance arrangements:

- Clinical leads (primary and secondary care), programme director, deputy LTC programme director, senior programme manager (WTE 0.5), deputy programme manager (WTE 0.5)
- NEL CVD Clinical Network
- Working groups - cardiac rehabilitation and establishing hypertension, atrial fibrillation, lipid management, heart failure
- Currently working to formalise the cardiology and cardiovascular disease joint working with the APC
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External governance by Cardiac ODN and regional and national programme

Key delivery risks currently being mitigated:

- ICB workforce capacity to support matrix working
- On-going clinical leadership at NEL and place
- Failure to formalise joint working agreements to link CVD & Cardiology affecting delivery of NEL wide plans to address regional, national and local ambitions.
- Financial reduction in NHS SDF funding in 23.24 (no mitigation)

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Diabetes / NEL and local place based leads / SRO Siobhan Harper, Workstream Director, NHS NEL Siobhan.harper@nhs.net

The benefits that north east London residents will experience by April 2024 and April 2026:

- April 2024:
  - **Improved outcomes** for people living with diabetes for people with diabetes by standardising diabetes care across primary, community and secondary care. Thresholds currently under development.
  - **Reduction of type 2 diagnoses / delayed onset** in residents developing Type 2 (T2) diabetes delivered through an increase the number of people referred and starting the National Diabetes Prevention Programme (DPP) 45% of eligible populations).
  - **Increase in the numbers** of people living with Type 2 diabetes who achieve T2 diabetes remission, delivered through increasing uptake of LCD (low Calorie Diet) national programme. Target 373 people.
  - **Improved self -management** delivered through an expansion of structured education and digital management tools. Target for uptake to structured education programmes XX and DWMP target to be confirmed by NHSE.
  - **Collaborative care planning** to support holistic assessment of need and agree individual care plans
  - **Personalised care** - population Health Management approach established to support risk stratification, cohort identification and optimal care interventions delivered through implementation of NEL LTC outcomes framework - diabetes
  - **Reduced length of stay** in hospital for people living with diabetes delivered through establishing NEL wide Diabetes inpatient specialist roles and Multi-disciplinary foot teams TBA
  - People living with diabetes can have more **confidence that a wide range of healthcare** staff understand how to manage diabetes delivered through diabetes workforce education programme
- April 2026:
  - Locally delivered TIDE (Type 1 disordered Eating) service
  - Robust transition pathways for children living with diabetes across NEL
  - Improved foetal outcomes for babies born to women with diabetes
  - Reduction in below and above knee amputations
  - Improved detection rates of Type 2 diabetes
  - Type 1 service framework embedded across NEL services

How this transformation programme reduces inequalities between north east London's residents and communities

Utilisation of health inequalities data across 4 of the programme

- By utilising deep dive data analysis into local participation rates to support target local campaigns to improve equitable access by age, gender, ethnicity & deprivation
- By working with partners including providers, residents to review diabetes care pathways to reduce inequalities and improve equity to services e.g., uptake and completion rates of diabetes prevention, remission, structured education access to CGM (continuous glucose monitoring), insulin pumps.
- By piloting innovative approaches e.g. HI tools in primary care that identify residents that at the highest risk of developing Type 2 diabetes
- Undertaking gap analysis across acute settings in relation DISN / MDFT provision and ensuring there is service coverage across NEL
- By undertaking a population Health Management to support risk stratification, cohort identification and optimal care interventions utilisation of risk stratification tools in a primary care setting

Key programme features and milestones:

- Business case developed for MDFT in TH, N, WF (April 2023)
- Primary Care diabetes dashboard updated to include inequalities data (October 2023)
- Diabetes 23.24 & 25.26 priorities agreed – NEL & place based leads (March 2023)
- Type 1 service framework gap analysis undertaken (August 2023)
- TIED business case developed in collaboration with regional and place-based teams (April 2024)
- Mobilisation of DPP provider – NEL & place based teams (July 2023)
- Alignment with APC outpatient programme to implement GIRFT recommendations and PIFU (Q3 23/24)
- Evaluation of 23.24 Digital structured education mobilised (February 2023)
- Rollout of LTC indicators (led contractually by primary care) – impacting on benefits (December 2023)
- Establishment of diabetes psychiatry resource across NEL (April 2024)
- Establish local action plans to drive improved uptake of structured education services including healthy living national programme (June 2023)
- DPP CEG health inequalities tool rolled out across NE (May 2023)
- Central Referrals programme for DPP rolled out across (May 2023)
- Group consultation pilot concluded, and evaluation report produced –April 2023
- COVID recovery projects delivered – across places (October 2023)
- Full recurrently funded DISN provision across NEL via WF place (August 2023)
- Full recurrently funded MDFT provision across NEL via TH & WF place – (December 2023)
- Launch of diabetes workforce education programme (May 2023)
- Type 2 pathway review complete and QI products undertaken – Newham (April 2023)

Further transformation to be planned in this area:

Over the next two years

- Establishment of TIED services across NEL
- Type 1 services framework implemented across NEL
- Establishment of group consultation model across NEL

Over years three to five

- NEL wide resident appropriate options for patient education
- Integration with related clinical networks – e.g., CVD, renal

Leadership and governance arrangements:

- Programme Director, Deputy Programme Director, Interim Senior programme manager, Project Manager, Clinical leadership (acute & PC) at workstream level
- Working groups established – NDPP, LCD, diabetic foot
- Working groups planned – Type 1, Structured education
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External assurance is via the Regional Diabetes Network and national programme

Programme funding:

- SDF funding NEL & place-based programmes of work (this is does not include diabetes local budgets e.g., in addition to BAU . Contracted recurrent funding
- SDF funding
  - 22.23 1.7m
  - 23.34 126k (90% reduction)

Key delivery risks currently being mitigated:

- ICB workforce capacity to support matrix working
- Financial reduction in NHS SDF funding in 23.24
- On-going clinical leadership at NEL and place
- Delivery against key programme areas as outlined in LTP commitments and planning guidance

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	
Long-term conditions		Employment and workforce	x	Prevention	x	Co-production	x	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Neurosciences Programme / NEL / Archna Mathur, Director of Performance & Assurance, NHS NEL- archnamathur@nhs.net

The benefits that North East London's residents will experience by April 2024 and April 2026:

April 2024:

- 90% of people presenting with symptoms of Transient Ischaemic Attack will have access 7 days a week to stroke professionals who can provide specialist assessment and treatment within 24 hours of symptom onset thus preventing long term disability
- 10% of eligible stroke admissions will have consistent 24/7 access to mechanical thrombectomy to reduce the impact of stroke
- All residents who experience a neurological condition will have equitable access to high quality specialist rehabilitation across the pathway of care (acute, bedded and community) to maximise outcomes for each individual

April 2026:

- All residents with a neurological condition will have rapid access to specialist care and advice to empower them to manage their own condition effectively and avoid repeated acute admissions
- Residents who require acute admission will have rapid access to high quality, specialist care
- All residents with a neurological condition will have access to the full range of specialist rehabilitation closer to home to maximise individual potential and reduce complications

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing unwarranted variation in access to specialist assessment and treatment within 24 hours of symptom onset for NEL residents with TIA which currently ranges between 40% for BHR residents to 92% for City and Hackney residents
- By ensuring NEL residents (up to 10% of all stroke admissions) can have consistent access to 24/7 mechanical thrombectomy for stroke within sector (currently only 5.8% receive this across BHR and 6.8% across Tower Hamlets, Newham, Waltham Forest and City and Hackney)
- By reducing unwarranted variation in :
  - access to hyper-acute rehabilitation for trauma patients (currently none available),
  - timely access to specialist inpatient neuro rehabilitation for people with tracheostomies (currently none available in sector)
  - level 2b bedded rehab (currently only 7 beds within the sector) so 27% of NEL residents wait more than 14 days in an acute setting to be assessed and 22% wait more than 42 days from assessment to transfer to specialist bedded rehab
  - access to specialist community rehab for people with stroke and neuro conditions (only 30% of eligible stroke survivors are discharged with early supported discharge; one place does not provide community neuro rehab; in other places there are significant waits of up to 5 weeks for intervention)

Key programme features and milestones:

- *Prevention* – improve detection and management of atrial fibrillation delivered through the LTC outcomes framework by Q2 23/24
  - Co-produce 7 day TIA service with residents so that 90% of people with TIA symptoms receive assessment and treatment within 24 hours of first presentation to a healthcare professional by September 2023
- *Acute care* – implement consistent 24/7 mechanical thrombectomy service by July 2023 so that 10% of stroke admissions receive this intervention and improve quality of care so that 90% of patients experience door to groin time at or under 90 minutes resulting in better outcomes (time is brain) by December 2023
  - establish 8 Rapid Access Acute Rehabilitation beds at the Royal London to improve patient outcomes and experience and reduce overall length of hospital stay by May 2023
  - Alignment with APC outpatient programme to implement GIRFT recommendations and PIFU (Q3 23/24)
- *Rehabilitation* –co-produce rehabilitation services that meet residents needs and ensure care is received in the right place at the right time (tracheostomy beds at RNRU by March 2024; level 2b beds by March 2024; community stroke and neuro rehab services by September 2023)

Further transformation to be planned in this area:

Over the next two years

- NEL vocational rehabilitation service
- Improve acute stroke standards and flow across the stroke pathway

Over years three to five

- NEL spasticity service
- Rehabilitation facilities for people with complex cognitive and behavioural challenges and disorders of consciousness

Programme funding:

- Stroke funding from NHS England:
  - £88,000 – community rehabilitation
  - £165,000 – programme clinical leadership

Leadership and governance arrangements:

- Programme Director, Deputy LTC Programme Director, informal clinical leadership, Senior Programme Manager
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External assurance is via the North London Respiratory Clinical Network, regional and national programme

Key delivery risks currently being mitigated:

- History and culture within teams and clinicians driving resistance to change
- Regional neurosciences mandated clinical networks not aligned to developing local priorities
- Lack of delivery against key programme areas as outlined in LTP commitments and planning guidance due to:
  - workforce availability to staff new clinical teams
  - ICB workforce capacity to support matrix workin
  - NEL and place clinical leadership

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	x	Personalised care	x	High-trust environment	
Long-term conditions	x	Employment and workforce		Prevention	x	Co-production	x	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Renal Clinical Network / NEL / SRO: Charlotte Stone, Programme Director. NHS NEL - charlotte.stone14@nhs.net

The benefits that North East London residents will experience by April [2024] and April [2031]:

April 2024:

- Prevent residents of NEL from Chronic Kidney Disease and prevent the progression of the disease – this is being done via:
  - Improved access to specialist CKD intervention clinics for all NEL residents. By 2024 virtual CKD Clinics will be available across NEL with the service in BHR due to go live.
  - Roll out of NEL/London Kidney Network CKD Pathways and roll out of SGLT2i guidance
- "Transplant First" - Develop model in AKCC (Advanced Kidney Care Clinic) to promote "Transplant first" as primary option for patients with AKCC and support Getting It Right First Time recommendation to increase pre-emptive transplantation – currently not meeting the target London average of 35% with NEL at 32%.
- Home therapies – Improved access to home therapies - by 2024 there will be an Independent Therapies Centre at Mile End Hospital (and a young person's unit) and by 2024 a Mosque dialysis Unit will be in place. Currently achieving target of 20% dialysis patients on home therapy - 78 patients either having haemodialysis at home, or in training to do so, with plans to increase this number.
- Improve peritoneal dialysis rates – currently meeting target of peritoneal dialysis with 251 patients on peritoneal dialysis, with plans to exceed the target.
- Care closer to home - Where Transplant or Home Therapy cannot be achieved for patients, to ensure that their care is as close to their home as possible including earlier engagement via outreach advanced kidney care clinics
- Improved outcomes of renal risk factors eg ACR and hypertension – via LTC outcomes framework

- By 31/32:
  - Specialise services proactively working as part of end to end pathway transformation approach, with a aim to reduce residents attending specialise service with preventable conditions by improving prevention programmes in NEL and halting the progression on LTCs
  - Maximise patient dialysing at home - 496 patients on home therapies by 31/32 (target of 28% of patients on home therapies by 2032).
  - Maximise patients being transplanted - 280 transplant operations completed in 31/32

How this transformation programme reduces inequalities between north east London's residents and communities:

- Through the development of the home-away-from-home haemodialysis unit at Mile End Hospital and Mosque Dialysis Unit – this will give access to home haemodialysis to those who do not live in suitable properties.
- Developing a plan to address the recommendations outlined in the Health Equity Audit completed by the London Kidney Network
- East London has a higher than expected number of patients with CKD stage 3-5 (given its population age-structure).Through the roll out of virtual Chronic Kidney Disease (CKD) Clinics in BHR by Q1 23/24 – thereby reducing variation and inequalities as BHR is currently an outlier
- NEL has higher than average did not attend (DNAs) for renal outpatient transformation which has been deprivation, working with the London Kidney Network we're working to improve health literacy and improving communication with residnets

Key programme features and milestones:

- Prevention: Implementation of the virtual CKD clinics in BHR using a single ICS specification (Q1 23/24)
- Renal Network: Develop a NEL Renal Strategy (including incorporating the NEL Health Equity plan) (Q2 23/24)
- Alignment with APC outpatient programme to implement GIRFT recommendations and PIFU (Q3 23/24)
- Dialysis & Home Therapies: Establishment of 2 home-from-home haemodialysis stations in the East London Mosque (Q3 23/24)
- Dialysis & Home Therapies: Independent Therapies Centre (ITC) at Mile End Hospital (building complete Q3 23/24)
- Prevention: Roll out of SGLT2i guidance (including development of guidance and education) (Q1 23/24)
- Prevention: Roll out of the London Kidney Network/NEL Chronic Kidney Disease Pathway (Q2 23/24)
- Roll out of the LTC outcomes framework with CKD indicators (Q2 23/24)
- Completion of Pilot in BHR – early identification of people with raised uACR. Evaluation is in Q1 22/23

Further transformation to be planned in this area:

Over the next two years

- Roll out of CKD dashboard and Learning health system approach to drive improvement in CKD identification and care
- Pharmacist led CKD desktop reviews to optimise medications including ACEi/ARB, SGLT2is and Statins
- Consultant led case based discussions sessions for education to facilitate transfer of expertise to frontline primary care
- Personalisation including BP self-monitoring, lifestyle and symptom monitoring/management
- Recall support for BP monitoring, bloods, uACR testing and annual reviews

Over years three to five

- Scoping for potential Dialysis hub in Hackney
- Community case finding in Places of Congregation with Point of care testing and BP checks

Programme funding:

- Funding of Independent Therapies Unit via Barts Charity
- Local place transformation funding

Leadership and governance arrangements:

- Clinical leads (primary and secondary care), senior programme manager (WTE 0.5) , deputy LTC programme director and programme director.
- NEL Renal Clinical network
- Working groups – Dialysis & home therapies, transplantation, prevention
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External assurance is via the London Kidney Network, NHS England regional and national teams.

Key delivery risks currently being mitigated:

- Capital funding for machines required for the Independent therapies centre
- On-going clinical leadership at NEL and place
- Resourcing the Renal Programme – Frailty/Supportive care on hold pending additional resource

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

2. Additional local strategic priorities

Transformation in NEL

North East London Health & Care Partnership

Respiratory Clinical Network Programme / NHS NEL / Gary Dark, Programme Manager, NHS NEL - gary.dark1@nhs.net & Paul Pfeffer, Respiratory Consultant, Bart's Health - paul.pfeffer1@nhs.net

The benefits that North East London's residents will experience by April 2024 and April 2026:

April 2024

- Improved access for local people to Early & Accurate Diagnosis of respiratory conditions delivered through Primary Care Hublets available in all 7 Places (currently provided in 3). This will reduce the inequality of waiting times and act as a catalyst to increasing the % of local people thar require a diagnostic test within 6 weeks in line with the national ambition of 95% by March 2025. For local people this will ensure earlier access to care and treatment and help plan ahead.
- Access to Virtual Wards Acute Respiratory Infection (ARI) available to local people in every NEL 'place' in time for winter 2023/24 (currently provided in 2 Places). This will facilitate care for local people in their own homes.
- Collaborative care planning to support holistic assessment of need and agree individual care plans. These plans will ensure that NEL residents live the life they want to live based on what is important to them.
- Improved access to pulmonary rehabilitation (PR) delivered through an increase in capacity& resources and tailored information. Ensuing the local population benefit from increased respiratory muscular strength (Subject to regional PR funding).
- People living with respiratory conditions can have more confidence that a wide range of healthcare staff understand how to manage respiratory disease delivered through respiratory workforce education programme. For the local population, this will improve best value (more cost-effective prescribing and less waste of medicine) and reduced harm.

April 2025/26

- 2025: Delegated responsibility for specialised commissioned services to NEL ICB will allow the local population a greater voice on how the services they use can be improved and how linkages of care across the end to end pathway can be improved (which will improve patient outcomes).
- 026: Develop a new end-to-end clinical pathway for COPD leading to Lung Volume Reduction Surgery where appropriate. This will for the local make lung function more effective and improve breathing ability and quality of life
- 2026:Pulmonary Rehab
  - Available to patients with all chronic lung conditions, including complex breathlessness, available in a mix of provision i.e. F2f, virtual.
  - Increasing the % of the eligible people who are referred from 52% to 90%.
  - Increasing the % of the people completing a PR course from 42% to 80%.
  - Increasing the % of PR service users starting a course in 90 days from 54% to 90%.
  - n/b patients participating in PR will benefit from an improved health related quality of life, improved exercise capacity, increase respiratory muscular strength and improved exertional dyspnoea, (Subject to regional PR funding)

How this transformation programme reduces inequalities between north east London's residents and communities:

- By April 2023 completed mapping of providers of respiratory care across NEL. This will comprehensively identify regional inequalities in provision, and the gap between required and available provision.
- From April 2023 use of a Severe Asthma Enhanced Patient Identification Scheme to identify local residents who might benefit from specialist care but have not requested referral from GP (currently under 20% of patients eligible for severe asthma biologics are receiving in NEL leading to thousands of preventable exacerbations / A&E attendances / hospitalisations).
- By winter 2023/24 all 'Places' will have accredited providers (Hublets) of Diagnostic Spirometry and FeNO to reduce inequalities across NEL (currently available in 3 Places with none-to-little provision in remaining 4 Places) to be followed by educational videos in all local languages to explain the why & how of respiratory diagnostic testing.
- By April 2024/25 Pulmonary Rehab (including patient education materials) will be available in a minimum of 5 local languages as a digital resources (currently limited availability for non-English speaking patients), for all common respiratory conditions (primarily currently available for patients with COPD). Content for this digital resource will be developed and co-produced by the 3rd sector and those with lived with experiences. Across the NEL footprint English spoken as a 1st language can be as low as 65% (Cencus 2021) **(Subject to regional PR funding)** .2 S021).
- By April 2025/26 new services for vulnerable NEL residents with no fixed abode, to try to bring proactive care with better diagnostics and immediate management to these patients

Key programme features and milestones:

- PR accreditation for all providers (Between 2023-2026/ HUH 2023). The local population with lived with experiences will complete an engagement exercise, to help improve current clinical pathways. **Subject to regional PR funding**
- New Digital PR DHI with shared-working between 'Places' (co-production beginning March 2023 with potential capacity for circa 250 extra participants a year).
- Alignment with APC outpatient programme to implement GIRFT recommendations and PIFU (Q2 23/24)
- New LTC framework and new inhaler formulary to incentivise respiratory diagnostics and personalised inhaler prescriptions to optimise care and reduce carbon costs Q2 23-24.
- Diagnostic hublets rolled out in all 7 NEL 'Places' (Q1 2023-24)
- ARI VWs rolled out in all 7 NEL 'Places' ('Winter 23/24).
- Ensure equity in access for vulnerable cohorts homeless and those suffering from mental health illness (September 2023 onwards). Colleagues from the 3rd sector and local people with lived with experiences will support in the co production of new access routes. **Subject to regional PR funding**

Further transformation to be planned in this area:

- Over the next two years
  - Severe Asthma Enhanced Patient Identification Scheme
  - New ILD, Home Ventilation & Breathlessness MDT networks
- Over years three to five
  - New pathway for Enhanced Patient Identification for LVRS
  - PR services for complex breathlessness
  - new services for vulnerable NEL pts with no fixed abode

Programme funding:

- Non-recurrent funding for Pulmonary Rehab £480,000 per annum. No current commitments for funding for 2023-24
- Non recurrent funding for ARTP £25,000 per annum. No current commitments for funding 2023-24
- All other activity to be delivered within existing budgets.

Leadership and governance arrangements:

- Acute clinical leadership at network level, Programme Directors, Deputy LTC programme director, senior programme manager (WTE 0.2), deputy programme manager (WTE 0.5)
- NEL respiratory Clinical Network
- Working groups established – PR, Oxygen, PR, Hublets & medicines optimisation.
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External assurance is via the North London Respiratory Clinical Network, regional and national programme

Key delivery risks currently being mitigated:

- Funding - concerns around Hublet funding and sustainability of current non-recurrent funding for PR, VWs etc.
- Limited physical site-capacity for some specialist services potentially delaying specialist treatments.
- ICB workforce capacity to support matrix working
- On-going clinical leadership at NEL and place

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce	X	Prevention	x	Co-production	x	Learning system	

North East London Health & Care Partnership

NEL ICB HIV Clinical Network Programme SRO: Charlotte Stone (charlotte.stone14@nhs.net)

The benefits that North East London's residents will experience by April 2024 and April 2026:

- April 2024
  - 90% of those who attend an Emergency Department (ED) will be tested for HIV.
  - Local people will experience more follow up care with investment in a community led peer programme with an aim to reduce by 70% the number of eligible patients that are lost to care/failed by care. This follow up care will include HIV testing, councelling, mentoring, group support, assurance and information and advice.
  - Reduced preventable deaths from HIV related causes increasing pathway resilience and optimising opportunities for joint working with the HIV community and ICS partners.
- More open conversations to raise the awareness, challenge unconscious bias and reduce sigma associated with HIV by working with local communities and charities, and working with people living with HIV.
  - Working with fast-track cities to train people living with HIV to become community ambassadors, and work with different parts of the health and social care sector to increase knowledge of HIV, with the aim to provide trauma-informed care based on the principles of safety, trust, choice, collaboration, empowerment and cultural competence.

- April 2026:
  - Delegated responsibility for specialised commissioned services to NEL ICB will allow local residents a greater voice on how the services and linkages of care across the end to end pathway can be improved (which will improve patient outcomes). This will be achieved by having a resident's voice embedded within the governance structure.
  - An 80% reduction in new HIV infections (based on 2022 new infection rates).
  - A 50% reduction in of patients diagnosed with AIDS within 3 months of diagnosis.
  - A 50% reduction in the number of deaths from HIV/AIDS.

How this transformation programme reduces inequalities between north east London's residents and communities:

- Currently the percentage of those that receives a HIV blood test varies (from 4% - 56%) depending on which acute hospital they visit. We are proactively with NEL trust, charities and local communities looking to improve pathways and awareness for opt out testing in AD's for HIV. With the aim of ensuring 70% of all appropriate attendees at ED get a HIV test by the end of Q1 2023/24 and 90% of all appropriate attendees at ED get a HIV test by the end of Q2 2023/24.
- A number of NEL 'Places have been identified as having a "very high" number of HIV diagnoses. We are working with community HIV services to improve access and commission partnership initiatives across the health/3rd sector and local authorities.
- Increase knowledge and access to sexual health information (for example STI, HIV and mpox) as well as HIV and STI testing amongst GBMSM and Bangladeshi GBMSM in 7 NEL 'Places'. This will be achieved via increased use and enhancement of AI chat bot technology and enhanced website functionality using latest design and development approaches.

Key programme features and milestones:

- All acute hospitals will provide blood tests to 70% of those who attend ED (Q1 2023/2024).
- All acute hospitals will provide blood tests to 90% of those who attend ED (Q2 2023/2024).
- Implementation of automated HIV blood requests at all NEL acute hospitals (Q1 2023/2024).
- To work in partnership with the HIV community, local charities and ICS stakeholders to co-design a community led peer intervention programme for patients that are lost to care/failed by care (March 2023).
- Work with fast-track cities, local charities listen and those within the local population that have lived with experiences to understand how we can co-design initiatives that moves towards trauma informed care across the pathway (medium term strategy 2023 –2025).

Further transformation to be planned in this area:

- Over the next two years:
- Business case to secure recurrent funding for HIV opt out testing in ED.
- Working with fast-track cities and local charities to improve education of our workforce and reduce stigma

Programme funding:

- HIV- (£1.1m)
  - 65% pathology costs / 35% end to end pathway improvements.

Leadership and governance arrangements:

- Programme Director, Clinical leadership across NEL for key programmes of work across acute setting, no overarching clinical lead. Approx 0.2WTE senior programme manager
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External assurance undertaken by regional and national specialised service programme

Key delivery risks currently being mitigated:

- Variation in the percentage of HIV blood tests completed in ED's – escalation meetings arranged with acute hospitals.
- The extent of key programme delivery and benefits for residents will be dependent on London regional funding for 2023-24 & 2023-25
- ICB workforce capacity to support matrix working

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	x	High-trust environment	X
Long-term conditions	x	Employment and workforce	x	Prevention		Co-production	x	Learning system	x

North East London Health & Care Partnership

NEL ICB Hepatitis & Liver Programme SRO Charlotte Stone (charlotte.stone14@nhs.net)

The benefits that North East London's residents will experience by April 2024 and April 2026:

- April 2024 – utilising the pillars contained within Roadmap to eliminating HCV in London
- ➢ 90% of residents who attend an Emergency Department (ED) will be tested for HBV and HCV (unless they opt out). The benefit to the local people will be that they will not live a life of not being diagnosed, which may have greater health implications in the future.
- The local population will experience more follow up care with investment in a community led peer programme with an aim to reduce by 70% the number of eligible patients that are lost to care/failed by care. This follow up care will include regular testing, counselling, mentoring, group support, assurance and information and advice.
- ➢ Reduced waiting times for local people requiring a first clinical intervention across NEL by increasing resilience and optimising opportunities for joint working. This will support early treatment and improve quality of life for local people.
- ➢ Co design awareness initiatives to reduce the stigma associated with hepatitis. This will be achieved by working with local communities, charities and people with lived with experiences. This will improve local people's lives as health professionals will become more knowledgeable, the general public's attitude and behaviours should change for the better, which should provide a better quality of life for local people with lived with experiences.
- Some disadvantaged and vulnerable groups are at risk of HCV. We plan to partner with homeless assessment centres and local communities to provide reach and treat support for local people who maybe more susceptible to hepatitis and liver disease. For local people with lived with experiences, this will ensure earlier access to care and treatment and support for planning ahead.

- April 2026:
- Delegated responsibility for specialised commissioned services to NEL ICB will allow local people a greater voice on how the services and linkages of care across the end to end pathway can be improved (which will improve patient outcomes). This will be achieved by ensuring local peoples voices are embedded in the governance structure.
- ➢ To achieve micro elimination of HCV across NEL (2025).
- ➢ Improved access to diagnostics and increase local prevention programmes by aligning with the British Liver Trust optimal pathway. This will support the reduction in the growth rate of liver disease (currently 20%).
- ➢ Access to HBV clinical services will be increased, offering patients care closer to home.
- ➢ Reduced waiting times for patients with a HBV positive diagnosis will reduce the likelihood of patients developing acute liver disease .

How this transformation programme reduces inequalities between north east London's residents and communities:

- The Hepatitis C Trust has identified that disadvantaged and vulnerable groups are disproportionally at risk of Hepatitis C. These groups include local people who are homeless, local people who inject drugs but are not in touch with treatment services and undocumented migrants and sex workers. Through partnership working with health and social care providers, local communities and those with lived with experiences, we will look to open the conversation regarding stigma. Reducing stigma will help increase the knowledge of health professionals, the general public's attitude and behaviours should change for the better, which should provide a better quality of life for local people with lived with experiences
- NEL has a 20% growth rate in liver disease year on year. This is directly linked to deprivation, obesity and excess alcohol consumption. We aim to increase prevention and halt the progression of liver disease by working towards British Liver Trust optimal pathway.

Key programme features and milestones:

HBV & HCV

- All acute hospitals will provide blood tests to 70% of those who attend ED (Q1 2023/2024).
- All acute hospitals will provide blood tests to 90% of those who attend ED (Q2 2023/2024).
- Recruitment of a community HCV/HBV nurse to enhance the current community programme (Q1 2023/2024).
- Implementation of automated HCV/HBV blood requests at all NEL acute hospitals (Q1 2023/2024)
- **North London Liver Disease Network**
- To co-design with NEL/regional colleagues and local people the scope and operating model for the North London Liver Disease Network (Q4 2022/2024).
- Approval of the operating model and funding by North London Programme Board and National specialise service team (April 2023).
- Agree across three North London ICS prioritises for liver disease for the remainder of 2023/24 (May 2023).

Further transformation to be planned in this area:

- **HBV&HCV**
- Business case to secure recurrent funding for HBV & HCV opt out testing in ED.

North London Liver Disease Network

- The agreement of outcome-based metrics to demonstrate the clinical value of the network (early detection rates for liver disease, the prevention of cirrhosis, reduced re-admission rates for patients with decompensated liver disease).

Programme funding:

- Funding provided via the Hepatitis ODN and via the A&E opt out testing - £767,538
- ODN funding 159,000

Leadership and governance arrangements:

- Programme Director, interim clinical ceadership being provide by ODN, senior programme manager (0.2WTE)
- North London Liver Clinical network (to be established 31st March 2023) which feeds into the Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established)
- External assurance undertaken by regional and national specialised service programme

Key delivery risks currently being mitigated:

- Variation in the percentage of HCV & HBV blood tests completed in ED's – escalation meetings arranged with acute hospitals.
- The extent of HCV/HBV key programme delivery and benefits for residents will be dependent on London regional funding for 2023/2024
- ICB workforce capacity to support matrix working
- Clinical leadership

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	x	Personalised care		High trusted environment	x
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	

North East London Health & Care Partnership

NEL ICB Haemoglobinopathies Clinical Network Programme SROs: : Archna Mathur (archnamathur@nhs.net) and Charlotte Stone (charlotte.stone14@nhs.net)

The benefits that North East London's residents will experience by April 2024 and April 2026:

April 2024

- Local people with sickle cell will receive appropriate analgesia and other pain management measures (ideally within 30 minutes) when attending any acute A&E in NEL
- Local people will expertise reduced variation across NEL within Specialist Haemoglobinopathy Team services, as we're working with teams to achieve to optimal pathways for diagnosis and management of sickle cell and thalassaemia.
- Residents will have timely access to multi-disciplinary team to support delivery of trauma-informed care based on the principles of safety, trust, choice, collaboration, empowerment and cultural competence.
- Local people will feel supported with an increase in awareness of sickle cell among healthcare professionals, as highlighted in No One's Listening report. For the local population, this will improve best value (more cost-effective prescribing and less waste of medicine) and reduced harm
- 84 children and young adults will have opportunity to be mentored by qualified Sickle Cell Society mentors to feel more empowered about their care, support health literacy and support them through transition between young adult and adult service

- April 2026:
- Delegated responsibility for specialised commissioned services to NEL ICB will allow the local population a greater voice on how the services and linkages of care across the end to end pathway can be improved (which will improve patient outcomes).This will be achieved by having a resident's voice embedded within the governance structure.
- Reduced treatment delays and/or reduce hospital admissions due to faster referral pathways for patients with complex disease (or needing high-cost interventions)
- Reducing duplication and saying their 'story' more than once by improving IT solutions in the urgent care pathway so every healthcare practioner can access the same care plan

How this transformation programme reduces inequalities between north east London's residents and communities:

- Barking and Dagenham have the highest rates of people with sickle cell disease. We will work with Specialist Haemoglobinopathy Team (SHT) at BHRUT to increase resilience and improve outreach to support local people.
- Within the age group of 10-24yrs, NEL has a rate of infection of between 400-700 per 100,000 for sickle cell disease. We will work with the Sickle Cell Society and ICS partners to extend the current mentoring programme to all eligible local residents within the10-24 yrs cohort (currently only delivered in City & Hackney) across the 7 'Places' to ensure equity of access.
- Work with local people with lived experience and local communities to co-design educational material to reduce stigma and provider greater opportunity of early diagnosis (including at birth), with a key focus on areas of deprivation - with local people living in the most deprived areas of NEL having almost 75% higher rates than areas in the second most deprived quintile. To note NEL has the highest level of deprivation of any London ICB.
- The Sickle Cell Society has identified sickle cell as a condition that predominantly affects people with African or Caribbean heritage and patients, the no one listening report highlighted racial inequalities in care across England, we are working with healthcare professionals to stop racists behaviours and challenge unconscious bias to reduce inequalities

Key programme features and milestones:

New programme – started in February 2023 and working with the specialise service Haemoglobinopathies Coordinating Centre (HCC)

The development of an ICB governance structure , that supports the HCC and provides assurance for the delegation of service from the London region (April 2023).

The delivery of a 'deep dive' to enable the HCC, the ICB and other key stakeholders understand and agree on the priorities for the next 12 months (April 2023).

Development of Trust specific business cases for accessing MedTech funding for automated exchange. This will reduce inequalities and support elective and emergency access to auto exchange 24/7. (Q4 2022/23).

- Implementation of recommendations from the APPG sickle cell report (No One is Listening) to ensure improved patient experiences. (Q2 2023/24)
- The increase of partnership working with pharmacy leads, the London red cell pharmacy group and Trusts to access new drugs (Q3 2023/24).
- Standardisation of service delivery. (Q4 2023/24).

Further transformation to be planned in this area:

- Over the next two years:
  - Address how workforce shortfalls can be mitigated against.
  - Improved data reporting of service users with haemoglobinopathies (currently only 50-70% of patients are recorded).
  - Develop a strategy to prevent acute exacerbations and end organ complications
  - Establish a learning and development framework. This will enable all healthcare professionals to be up-skilled in the management of sickle cell disease.

Programme funding:

- Funding via HCC and direct to trusts for programmes

Leadership and governance arrangements:

- Programme Director, 0.3WTE of a programme manager. Interim clinical leadership being provided with support of HCC, while we secure funding
- Internal assurance is via the specialise service and LTC (NEL LTC programme board being established) governance
- NEL working with HCC's to support service delivery and improving linages of care across the end to end pathway
- External governance regional and national programmes

Key delivery risks currently being mitigated:

- Workforce capacity to support the standardisation of the SHT at Queens, ICB, LTC and Specialised Services directorate are providing additional resource.
- The level of funding received from the London region is insufficient to meet the service specification. A services 'deep dive' will help to better understand the challenges.
- ICB workforce capacity to support matrix working

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	X	Personalised care	x	High-trust environment	X
Long-term conditions	x	Employment and workforce	x	Prevention		Co-production	x	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Prevention/Prohab / Barking and Dagenham, Havering, and Redbridge place partnerships / Jeremy Kidd, Deputy Director of LTC, NHS NEL -jeremy.kidd1@nhs.net

The benefits that Barking, Havering & Redbridge [BHR] residents will experience by April 2024 and 2029:

By 2024

- Population-level approaches to reducing cardiovascular disease via targeted themes and campaigns
- Linking population approaches to individual approaches in primary care
- Improve management of disease-specific cardiovascular disease to reduce level of risk and increase early identification of condition-specific disease
- Improve effective early management of condition-specific cardiovascular disease
- Improved management of **CVD risk factors** eg ACR and hypertension – via LTC outcomes framework (thresholds tbc)

By 2029

- Leverage analytics/algorithms and visualisation tools to understand, track and report on population activity and measure improvements
- Improved coordination between population approaches and individual approaches in reducing risk, increasing early identification and effective management of those
- Residents know who, where, how and when to access -services/teams, flexed to the needs of place. The culture of good/better health will become the norm rather than waiting until ill health presents before they receive appropriate care
- Greater peer led community support and engagement to enable self-care and lower acute care utilisation, reducing non-elective [NEL] admissions/readmissions & A&E attendances for the major LTCs
- Improve the number of people with high blood pressure are diagnosed; improve the total number of people already diagnosed with high blood pressure are treated to target as per NICE guidelines

How this transformation programme reduces inequalities between north east London's residents and communities:

- Understanding the whole risk reduction agenda from cradle to grave better in order to put in place planned strategies to engage people to own their own health, to attain good or better health at any stage of their lives, with or without identified CVD [prohab].
- Maximising opportunities to identify CVD conditions early, initiate treatment promptly and refer swiftly if indicated.
- Understanding and removing any practical barriers that prevent some residents from seeking access to health services, and participating in population or individual interventions
- Improving the quality of patient-health professional contacts in partnership working to support individuals in making good decisions regarding their health/their families' health to motivate people towards good/better health at all stages of their life.
- Strengthen the role of voluntary, charitable and community sector providers in working with individuals/families and remove any constraints and barriers to that happening.

Key programme features and milestones:

- The role of Place from 2023 onwards in ensuring delivery of end to end pathways and the importance of promoting good/better health [prohab] at all stages of a person's life
- Developing a completely different approach to health and illness [rather than the traditional patriarchal approach], promoting ownership of an individual's health and good health throughout life, so working holistically in partnership with individuals rather than mainly treating illness.
- Continuing to deliver the projects currently underway looking at early identification and treatment.
- Much greater emphasis on identifying individuals potentially at risk at a much earlier age, using whatever means are more appropriate for our local population
- Specific cohorts of people with raised/borderline [estimated ~63K in BHR] hypertension and/or chronic kidney disease [CKD] , people requiring potential weight management needs [rising numbers in Type 2 diabetes secondary to obesity – now presenting in children of primary school age]

Further transformation to be planned in this area:

Over the next two to five years

- Development of CVD dashboards that provide actionable insights
- Scoping opportunities for standardising access, delivering care, supporting ownership of one's own health, promoting good/ better health not just treating illness, from cradle to grave holistically
- Continue implementing the new model of co-production

Programme funding:

- Identifying current services and roles already funded and in place, and 'repurposing' the skills and experience of individuals identified.
- Unknown at present for any identified gaps but potentially aiming to provide new model within existing envelop of monies from different providers

Leadership and governance arrangements:

- Place-based partnership actively participating in the newly formed PRIME working group [formerly the EIFR Working Group]
- NEL Clinical Networks: Cardiovascular Clinical Network; Renal Clinical Network
- Pan-London [Regional] Renal Network

Key delivery risks currently not being mitigated:

- CVD risk assessment using a tool that is **not** relevant to a large majority of our potential 'at risk' local population
- Delay in developing a new generic Prohab team that could provide access to many more individuals with overt CVD/respiratory conditions [currently accessing condition-specific rehab programmes with limited spaces available], as well as 'prehab' for individuals seeking to optimise their health such as people seeking weight management support, hypertension etc
- Understanding of whole-system-change and the opportunity to be really innovative could suppress meaningful transformation plans for this very important workstream

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Diabetes / Barking and Dagenham, Havering, and Redbridge place partnerships / Jeremy Kidd, Deputy Director of LTC, NHS NEL -jeremy.kidd1@nhs.net

The benefits that NEL residents will experience by April 2024 and 2026:

By 2024

- The number of BHR residents with diabetes (T2) receiving eight care processes (8CP) in primary care increase in number (70%+); the quality of process checks improves allowing both better health and early referral when necessary (e.g. foot health or renal)
- CYP diagnosed with diabetes (T1) are supported by a Transition service (ages 12-25) that equips them for later-life and is supported by new capabilities of Insulin Pumps and Continuous Glucose Monitoring (CGM) – which are also for adult residents
- PCN leadership at Place establishes community links with residents (LA supported and via charities, faith groups and schools) that begin to address false beliefs about diabetes and promotes life-style change. This supports reduction in the at-risk of diabetes cohort (NDH) and pilots capability around diabetes remission.
- Review of pathway and referral thresholds increases workforce empowerment and resident access.

By 2026

- Improved health and wellbeing for residents, particularly those with long term conditions
- The level of 8CP delivery is high (80%+) and stable; year-on-year improvements in numbers controlled (target 70%+); QI improvements have led to improved referrals and starting to reduce care required for complications (e.g. amputations)
- CYP capacity at acute improved by Transition services whose first 'graduates' are expert-users in Pump and CGM technology which reduces hospital care and improves quality of life; advice to pregnant woman with diabetes, as well as those planning pregnancy, reduces complications including avoidable birth defects
- Place-based networks for diabetes are maturing and providing contact-points for local residents either who have diabetes, are concerned about diabetes for themselves or friends/family or generally want to live healthier.
- New capabilities of Insulin Pumps and CGM are present in acute and community; this improves quality of life, employment options and reduces emergency care; workforce skills are enhanced and NEL starts be known as a great place to deliver diabetes care
- Residents know where, when and how to access the care they need for the assessment and management of long-term conditions; no longer have to 'feel worse' to receive care
- Residents with health conditions will be assessed, identified and provided with condition management as early as possible.

How this transformation programme reduces inequalities between north east London's residents and communities:

- Primary care delivery of diabetes care was significantly impacted by Covid-19; the evidence shows that in London that residents with diabetes but who did not get Covid-19 have experienced an increased death-rate. In addition, deprivation, ethnicity and the greater incidence of key workers in East London increases the risk to residents with diabetes.
- The current service gap of no CYP Transition service was highlighted by a GIRFT peer-review of BHRUT and contrasts with BH Trust which was funded to pilot Transition services. Similarly, offering Insulin Pumps in BHR will match BHRUT to BH capabilities, while a comprehensive offer of a CGM capability across NEL has potential to radically improve the lives of residents of working-age who suffer poor diabetic control.
- Place-based community mobilisation around living with or avoiding diabetes will be critical in arresting the current growth of diabetes trajectories which will otherwise undercut our residents economic prosperity and our health economy; this work needs to be community and culturally informed.

Key programme features and milestones:

- Establish Governance for 2023-24 and forward, including linkage to Place
- Primary care (Q1-Q4)
  - Delivery of LTC LIS and transition to LTC Outcomes Framework
  - Develop PCN diabetes leadership and their mobilisation of Place networks, Training and QI programmes
  - Review Injectables (Q2)
- Business cases; for Transition, Insulin Pumps, CGM and Community Redesign (Q1)
- Full system diabetes pathway review and criteria
- Secondary
  - Recruit lead consultant for Transition plus other staff for team (Q3)
  - Plan Pumps and CGM programme with Community Care (Q2)
  - Start Transition, Pumps and CGM (earliest Q3 or by Q4)
  - Develop a NEL CVD Strategy (Q2 23/24), Start MH (T1) service (Q2)
- Community
  - Review BHR services to equalise offer (Q1-Q3)
  - Move to new delivery model (Q4 and developed through 2024-25)
- Other; work with enablers, e.g. CEPN, CEG etc.

Further transformation to be planned in this area:

Over next two to five years

- Patient Education; develop resident appropriate options and healthy-living programmes that resident want to complete
- Integration with related schemes as they develop e.g. Obesity, Hypertension, Renal
- Providing support to enable independent living for as long as possible via the development of integrated teams

Programme funding*:

Currently costed scheme,

* Sources of funding to be identified

- Transition service* £365k and Primary care; £1,800k

Schemes being estimated

- Pumps, CGM* £600k and Community care redesign* (too early)

Leadership and governance arrangements:

- Level 1 – BHR LTC Board (or its successor)
- Level 2 – NEL Diabetes Partnership Board
- Level 3 (operational) – Diabetes Operational Working Group (or its successor)

Success will need co-ordination or contract management with:

- Networks; NHSE London, Primary Care (local and London), CVD, Obesity, Renal, Hypertension, UCLP
- Partners; BHRUT, NELFT, PCNs, Prescribing
- Other providers; Xyla, CEG, Oviva, Federations, et al.

Key delivery risks currently being mitigated:

- Funding: low availability or funds will supress transformation plans; mitigate through work understanding whole-system-impact and efficiencies of
- Workforce: attraction and retention could limit development; mitigate through inter-provider work and skills transfer (e.g. pumps) plus training (CEPN)

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Cardiology (HFrEF & HFpEF)–/ Barking and Dagenham, Havering, and Redbridge place partnerships / Jeremy Kidd, Deputy Director of LTC, NHS NEL -jeremy.kidd1@nhs.net

The benefits that Barking, Havering and Redbridge residents will experience by April 2024 and 2029:

By 2024
- Reducing variation in practice for people with **heart failure**, improving care and outcomes for patients who access acute, community and primary care
- Delivering good links via integration between community and acute via multidisciplinary team (**MDT)** meetings
- Improve **cardiac rehabilitation (CR)** to include cancer pre-rehabilitation and pulmonary rehabilitation
- Strengthen **health psychology** offer to reflect multimorbidity
- Explore, develop and scale up **Heart failure@Home**
- Strengthen the **Cardiac Prevention Pathway** through behaviour change communications which will encourage people to seek advice/promote the importance of risk factor management

By 2029
- All patients with with suspected heart failure and NT-proBNP >400 ng/l will receive urgent referral for specialist assessment and echocardiography at Place
- All patients with advanced heart failures will receive Heart Failure Specialist advice or review
- Improved psychological wellbeing of patients with heart failure will increase healthy longevity, improving quality of life, preserving good mental health and cognitive function, and achieving health care savings on individual &system level.
- More people managed from the comfort of their home and improving virtual care
- Increasing number of patients will be able to self-manage their conditions

How this transformation programme reduces inequalities between BHR Places residents and communities:
- Through service standardisation- single point of access, standardised clinical management pathways across BHR Places, discharge process and information to primary care, access to advanced medications across BHR, referral criteria, use of patient literature and patient information sheet.
- HFrEF scheme will impact on these improvement areas: reduce waiting times, possible development of PHP, expansion of MDT to include renal and palliative care, additional training on EOL, UCP and relationship building with specialist palliative teams and promote education and self-care, and exercise programme
- The schemes will improve greater access to community interventions, digital solutions and health literacy support tailored to at-risk groups
- CR is part of a multilevel approach addressing barriers related to healthcare system access and improving provision, referral and participation in high risk groups

Key programme features and milestones:
- Establish Governance for 2023-24 and forward, including linkage to Place. Reporting at "End -to-End Pathways Working Group (COCWP) ongoing
- HFrEF Phase 2:
  - Review Phase 1 (Q1 23/24)
  - Ensure maximum utilisation of existing HFrEF service (from Q2 to Q4 2023/24);
  - Ensure that the service is using efficient and effective systems and technology to deliver the service
  - Ensure standard access to other services including; Dietetics/ NHS Psychological Therapies Service (IAPT)/ Health Psychology/ End of life-Co-ordinate My Care (CMC)/ Hospice/ Expert Patient Programmes (EPP) (Q1 23/24)
- HFrEF Phase 3:
  - Enhance and expand in business case HFrEF service
  - Create an innovative service that can respond and adapt to the changing needs of the local health economy (digital technology, NHS@Home)
- Business case for HFpEP in Q4 23/24
- Standardise community cardiac service with integration with acute-WX, BHRUT

Further transformation to be planned in this area:
- Over the next two to five years
  - Business case to stand up cardiac rehabilitation service for heart failure patients across BHR Places in community
  - Scoping opportunities for streamlining access to cardiac diagnostics/ ancillary for care

Leadership and governance arrangements:
- Level 1: Place based Partnership
- Level 2: LTC Board (or architype/successor)
- Level 3: NEL Cardiac Clinical Network

Success will depend on Collaboratives with BHRUT/NELFT; Place is a crucial determinant and NEL Business case process.
Given the increasing multimorbidity of LTCs, a cardiometabolic approach to risk and commitment to end-to-end pathways is important. Not viewing cardiac pathways in silos but understanding close links with Diabetes, Respiratory and CKD. Prevention including LA schemes directed at upstream.

Programme funding:
Current cost of HFrEF
- £750K

Estimated cost of HFpEF
- Yet to be determined (Source= unknown)

Key delivery risks currently being mitigated:
- Workforce to staff schemes: attraction and retention which will be mitigated through skill mix, new lower band roles and continued training for practitioners (Primary/Community)
- No identified funding to progress HFpEF thereby inequalities and inequities will be sustained

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Diabetes / Tower Hamlets, Newham & Waltham Forest place partnerships / Kay Saini kay.saini@nhs.net

The benefits that NEL residents will experience by April 2024 and 2026:

By 2024
- The number of TNW residents with diabetes (T2) receiving eight care processes (8CP) in primary care increase in number (75%+); the quality of process checks improves allowing both better health and early referral when necessary (e.g. foot health or renal)
- CYP diagnosed with diabetes (T1) are supported by a Transition service (ages 12-25) that equips them for later-life and is supported by new capabilities of Insulin Pumps and Continuous Glucose Monitoring (CGM) and/or other NHSE/NICE recommendations for transitioning to adult care.
- Diabetic Foot Service continued for 12 consisting of 2WTE in partnership with Barts and NELFT
- Increased referrals to LCD, NDPP, Digital Weight Management by at least 15% in 23/24
- Review of pathway and referral timeline in all three places, aiming to achieve a seamless patient care and referral system between primary care, secondary care and community services
- Introduction of Healthcare Assistants across TNW to help achieve better outcomes (8 CPs, Social Prescribing, referrals, SE)

By 2026
- The level of 8CP delivery is high (85%+) and stable; year-on-year improvements in numbers controlled (target 75%+); QI improvements have led to improved referrals and starting to reduce care required for complications (e.g. amputations)
- CYP capacity at acute improved by Transition services whose first 'graduates' are expert-users in Pump and CGM technology which reduces hospital care and increases self-management
- Place-based diabetes pathways are functioning well in all three places; patients are better equipped with knowledge about their conditions and understand their condition better, including self-referrals, which leads to better quality of life
- New capabilities of Insulin Pumps and CGM are present in acute and community, which raises the current standard of diabetes care in TNW for T1, raising places' profile with neighbouring ICBs and nationally.
- Diabetic foot service consisting of 2.5WTE is embedded as a standard service, ensuring early intervention that leads to reduction of foot amputations
- Structured Education is embedded in all discussions between health professionals and patients, increasing referrals from 57% to 75%+

How this transformation programme reduces inequalities between north east London's residents and communities:
- Primary care delivery of diabetes care was significantly impacted by Covid-19; the evidence shows that in London that residents with diabetes but who did not get Covid-19 have experienced an increased death-rate. In addition, deprivation, ethnicity and the greater incidence of key workers in East London increases the risk to residents with diabetes.
- Foot amputations remain a concern across TNW, an area where significant work needs to be put in place to bring the rate of amputations to below national rates, showcasing TNW as a benchmark of good health outcomes
- Place-based community mobilisation, close collaboration with Public health around living with or avoiding diabetes will be critical in developing long term strategies, which should include a strong prevention agenda in all its operations, therefore collaboration with other sectors will be crucial; e.g. LA education dept to include aspects of diabetes prevention in their healthy living programmes.
- Hard to reach parts of the community due to cultural and/or language barriers will continue to be a priority for health care services in TNW calling for closer coproduction with local community organisations.

Key programme features and milestones:
- Establish Governance for 2023-24 and forward, including linkage to Place
- Primary care (Q1-Q4)
  - Delivery of LTC LIS and transition to LTC Outcomes Framework
  - Conclude pathway reviews in each place, producing an easy to follow procedure and diagram for healthcare professionals, made available as a point of reference to patients, family members and community organisations.
  - Reach a definitive decision re introduction of HCAs, including a detailed timeline for mobilisation (Q1)
  - Set up a steering group to review gaps in transitioning from T1 to T2 (Q2); including discussions provision of pumps; using BHR's findings as a benchmark for potential implementation a similar approach in TNW.
  - Review DISN services in each place in collaboration with clinical leads and other interested parties to establish if it is fit for service in each place and produce recommendations for improvement (Q3)
  - Finalise the Group Consultation Training across chosen PCN's (Q1); consider a wider offer in 24/25
- Secondary
- Business cases: Diabetic Foot Service
- Community
  - Link BP@Home with CVD so that the same process covers both diabetes and CVD (Q2)
  - Set dates for template training to be delivered by CEG to practices in each place (online)

Further transformation to be planned in this area:

Over next two to five years
- Prevention Diabetic Foot Disease given a high priority, seeking to reduce amputations significantly in each place aiming to raise each place's profile above national levels.
- aim to have 95% of patients completing 8CPs by 2026
- Establishing MDTs in WF and TH

Programme funding*:

Currently costed scheme,
- HCA Service £230K

Schemes being estimated
- Pumps, CGM* £600k (based on BHR)
- Admin support for MDT meetings in Newham: (TBC)

* Sources of funding to be identified

Leadership and governance arrangements:
- Level 1 – TWN LTC (or its successor)
- Level 2 – NEL Diabetes Clinical Network
- Diabetes Pathway Review Steering Group

Success will need co-ordination or contract management with:
- Networks; NHSE London, Primary Care (local and London), CVD, Obesity, Renal, Hypertension, UCLP
- Partners; Barts, RLH, ELFT, NELFT, PCNs, Prescribing, Community Pharmacy
- Other providers; Xyla, CEG, Oviva, Federations, Diabetes UK, etc..

Key delivery risks currently being mitigated:
- Funding: reduced funding will be the main factor in delivering new programmes such as HCAs and/or embedding Diabetic Foot service post 23/24.
- Workforce both in the team and in front line service could be an factor in delaying delivery of programmes inter-provider work and skills transfer (e.g. pumps) plus training (CEPN)
- Prolonged process of restructure at NEL is likely to cause uncertainty and delays at local level.
- Lack of clarity from ICB about roles, guidance, expectations, and timescales including mixed messages that will cause unnecessary delays and confusion.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Cardiology / Tower Hamlets, Newham, and Waltham Forest place partnerships / William Cunningham-Davis

The benefits that Tower Hamlets, Newham, and Waltham Forest residents will experience by April 2024 and 2029:

By 2024
- Reducing variation in service provision for people with **heart failure**
- Reducing variation in service provision for residents requiring **cardiac rehabilitation (CR)**
- **Improving CR** pathways, as well as uptake and completion rates amongst eligible population
- Improved early and accurate diagnosis of CVD through **BP screening, lipid testing, and AF detection**
- Improved access to hypertension and anti-coag. monitoring services, including **optimisation of meds**

By 2029
- Increasing number of patients engaging with self-management tools and initiatives
- Improve Community Cardiology service provision and access to care closer to home

How this transformation programme reduces inequalities between TNW Places residents and communities:
- The ongoing and new schemes will improve access to community interventions, as well as self-management
- By proactive case finding in areas of deprivation and amongst communities less likely to access healthcare to reduce the prevalence gap
- By Improving access to services by delivering care closer to home, including self-management
- By taking a population management approach to tackle health inequalities
- By reducing variation in care and targeted communication and support material to overcome language barrier/cultural difference
- Expansion of the CR service has included an evaluation exercise of other CR services within the NEL system, the outcome of which is being used to inform the roll-out and delivery of the service. This service will improve accessibility for local residents in and around Waltham Forest, feeding into existing pathways, including community HF, and facilitating direct referral pathways from primary care, as well as self-referral.

Key programme features and milestones:
- Complete hypertension inequalities pilot to reduce number of uncontrolled hypertensive patients against baseline – Q3
- Ongoing delivery of communications plan to improve uptake and utilisation of home BP monitors – Q1 & Q2
- Develop business case for proactive case finding of patients at risk of developing AF and hypertension – Q4
- Launch CR service in Whipps Cross – Q2
- Review and align anti-coagulation services in Newham with LTC outcomes framework and identify opportunities to meet IIF targets
- Launch InHIP – diagnostic and case-finding of hypertension & hyperlipidaemia and medicines optimisation - Q2
- Review Community pharmacy anti-coagulation service – Q2
- Scoping exercise for community based anti-coagulation service to include DOAC initiation pending review of anti-coagulation provision at NEL level (TBC)
- Develop BC for Community cardiology service in Newham – Q3/Q4
- Evaluate Community anti-coagulation service in WF – Q4

Further transformation to be planned in this area:

Over the next two to five years
- Scoping opportunities for cardiac diagnostics at Community diagnostic centres

Programme funding:
- Hypertension inequalities pilot £30K
- InHIP (Newham) £50k
- Whipps Cross CR £365k
- BP@Home extension - £15K
- Other funding TBC

Leadership and governance arrangements:
- Cardiac Clinical Reference Group (NEL)
- North London Cardiac Rehabilitation working Group
- Place-based Partnership Groups
- Primary Care Transformation Groups

Key delivery risks currently being mitigated:
- Prolonged process of restructure at NEL and impending change in team capacity, portfolio, and function may impact on delivery of workstreams – plans developed for ongoing delivery
- Ongoing recruitment and retention challenges across the system, i. e. cardiac rehabilitation specialists – opportunities being considered to recruit exercise specialists with transferable skills and knowledge

Alignment to the integrated care strategy:										
Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Respiratory: Transformation in NEL

North East London Health & Care Partnership

Respiratory / TNW / [William Cunningham-Davis, william.cunningham-davis@nhs.net]

The benefits that Tower Hamlets, Newham and Waltham Forest residents will experience by April 2024 and April 2026:

- Improved early and accurate diagnosis of asthma and COPD by implementation of Respiratory Hublets
- Improved outcomes for patients with respiratory disease via the provision of information to support better self-management
- Greater access to Pulmonary Rehabilitation service to support better outcomes from respiratory disease
- Reduction in number of people smoking to below England average by 2026.
- Less exacerbations and hospital admissions through better management in the community
- Improved outcomes from medicines through specialist led reviews in Primary Care
- Improved seamless Respiratory Pathway for better management of respiratory conditions

How this transformation programme reduces inequalities between north east London's residents and communities:

- By proactive case finding in areas of deprivation and amongst communities less likely to access healthcare to help address the prevalence gap
- By applying a population management approach to identify health inequalities and implementing bespoke strategies
- By reducing variation in care through better access to services, delivering care closer to home and self-management tools/information which takes in to account language barriers/cultural differences
- By increasing uptake of flu, covid-19 and pneumococcal vaccinations to support patients to reduce infective exacerbations and emergency hospital admissions due to those exacerbations, through local targeted campaigns
- By targeting those patients at high risk of admissions to prevent worsening of their condition through earlier interventions

Key programme features and milestones:

Prevention and Earlier and Accurate Diagnosis

- Delivery of communications plan to increase referrals in to pulmonary rehabilitation services - TNW
- Engagement via PCNs to identify and refer patients with undiagnosed /high-risk COPD in Primary Care using CEG searches - TNW
- Champion The Healthier Lives programmes in Newham
- Re-Procurement of TH Good Moves Service
- Mobilisation of the respiratory Hublets at Place- TNW

Better Management

- Complete Respiratory inequalities pilot to reduce number of uncontrolled respiratory patients against baseline – WF
- Review the current NELFT Respiratory specification and pathway to identify gaps and inequality in respiratory provision across WF. Development of a concept paper and subsequent development of BC for NELFT community service
- Upskill workforce via training and education sessions to support the delivery of better management in Primary Care-TNW
- Socialise the Pulmonary Rehabilitation Service in Primary Care through local patient campaigns- TNW
- Support the development of the business case for a Home Oxygen Service -Newham
- Embed UCLP risk stratification search via PCN engagement to help identify and priortise patients in need of further support with their management -TNW
- Review of the LTC data sets to devise realistic placed based targets for LTC LIS. Collaborate with Primary Care and support roll out of the LTC LIS and transition to LTC Outcomes Framework- TNW
- Review and update draft respiratory pathway- TNW
- Continue to input into the WF Delivery Groups to support mobilisation of Care closer to home & Centre of excellence programme with the aim to better manage patients who at the highest risk of a non-elective admissions tbc
- Re-introduce the specialist respiratory reviews service, prioritising PCNs with patients at highest risk of an exacerbation-WF

Further transformation to be planned in this area:

Over the next two years

- Review of the NELFT respiratory Service
- Patient Education and support tools
- Develop appropriate options and healthy-living programmes that resident want to complete
- Integration with related schemes as they develop e.g. Obesity, Hypertension, Renal
- Re-Procurement of TH Good Moves Service
- Explore the opportunities to incorporate digital and remote monitoring services to support patients with LTC
- Embed the use of the risk stratification approach in BAU to support prioritisation of high risk patientsatory pathway

Programme funding:

- Primary Care funding, SDF funding
- Part of WX redevelopment funding Section 256 funding

Leadership and governance arrangements:

- NEL Respiratory Clinical Network
- WF LTC Delivery Group
- Primary Care transformation Delivery Board

Key delivery risks currently being mitigated:

- Funding not secured due to a financial reduction in NHS
- Insufficient LTC staff in TNW due to lack of permanent staff and team vacancies
- Sustainable delivery due internal re-structure in ICB
- Non-engagement from PCNs
- Workforce: attraction and retention could limit development;

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	x	Personalised care	x	High-trust environment	
Long-term conditions	x	Employment and workforce	x	Prevention		Co-production		Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Improving outcomes for people with long term health and care needs /City and Hackney Place / Nina Griffith, Workstream Director, NHS NEL, nina.griffith@nhs.net

The benefits that City and Hackney residents will experience by April 2024 and April 2026:

- April 2024:
  - Health outcomes for residents with LTCs have improved to at or near pre-pandemic levels
  - Residents have the opportunity to participate in self-management programmes (e.g. BP@home or Digital Structured Education for diabetes)
  - Residents have access to high quality diagnostics locally – e.g. Spirometry
- April 2026:
  - Communities that find it harder to access services will have opportunities to engage
  - Increased focus on prevention and "upstream services" such as community and primary care
  - Access to out of hospital care at time of need e.g. rapid diuresis service for Heart Failure services

How this transformation programme reduces inequalities between north east London's residents and communities:

- By working with our voluntary sector providers to engage specific communities e.g. through our community champions programme and Social Prescribing Outreach Programme
- By working with our population health hub and PCNs to identify and address specific inequalities
- By working with the neighbourhoods team to pilot approaches to including wider determinants of health in our approach to condition management
- By making our services more accessible to residents such as via women's health hubs in the community
- By ensuring that risk stratification approaches are embedded in our local approach to population health management

Key programme features and milestones:

- Local LIS for Long Term Conditions
- NEL LTC outcomes framework
- Development of a system-wide personalised care strategy
- Ongoing work with local Public Health to join up prevention approaches on lifestyle services such as weight management and smoking cessation
- Building on existing good relationships between primary and secondary care clinicians to achieve excellent care for residents: including end to end clinical pathways, outpatient transformation and local approaches to implementing National or Regional projects
- Link with NEL wide clinical networks to align local and regional priorities

Further transformation to be planned in this area:

Over the next two years

- Continued focus on primary / secondary care interface to strengthen partnerships and best outcomes for residents
- Scope out further opportunities to bring specialist expertise into community settings
- Link to other programmes of work such as digital and out of hospital care to maximise benefits

Over years three to five

- Embed personalisation via the neighbourhoods transformation work
- Refine approach to risk stratification in primary care to enable targeted approach

Programme funding:

- Local LIS funding
- NHSE funding for specific programmes such as diabetes
- Non-recurrent funding for pilot schemes

Leadership and governance arrangements:

- Local clinical leads in partnership with LTC, planned care, neighbourhoods and PH teams
- Place based partnership Delivery Group
- Neighbourhood Health and Care Board and City and Hackney Health and Care Board

Key delivery risks currently being mitigated:

- Reduced funding for innovation and pilots (including from NHSE)
- Recruitment difficulties for some front line staff groups
- Lack of primary and secondary care clinical capacity to drive forward change

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	x	Personalised care	x	High-trust environment	
Long-term conditions	x	Employment and workforce		Prevention	x	Co-production	x	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Improving outcomes for people with long term health and care needs - Enhanced community response / City and Hackney Place Based Partnership / SRO TBC

The benefits that City and Hackney residents will experience by April [2024] and April [2026]:

- April 2024:
  - Consistent access to urgent community response as a safe alternative to ED for patients in crisis
  - Access to a frailty and respiratory virtual ward as a safe alternative to hospital admission
  - Better continuity of care post crisis to ensure complete recovery and reduce risk of further crisis
- April 2026:
  - More people managed safely in the community as an alternative to ED / acute admission
    - Increased - supported by appropriate use of technology
    - Increased range of clinical conditions to meet assessed need
  - Fewer people experiencing crisis
  - Increased patient choice and personalised care at home

How this transformation programme reduces inequalities between north east London's residents and communities:

- By supporting vulnerable frail cohort to receive consistent acute level care in their own homes
- By ensuring equity of access and supporting referrals from system partners
- By reducing variation in avoidable use of urgent and emergency care services including LAS and ED
- By providing flexible employment opportunities
- By using population health data to target investment in areas of greatest assessed need

Key programme features and milestones:

Urgent community response
- Robust delivery of 2 hour crisis response standard.
- Maximising referrals from all sources – including LAS and self-referral
- Explore need / potential impact of extended hours and broadened scope
- Evaluating impact and outcomes
- Developing interface with emerging virtual wards

Virtual wards
- Partnership collaboration to design and implement virtual ward model for clinical priority areas of Frailty and ARI.
- Develop a sustainable workforce model that supports the clinical pathways as they mature
- Exploring potential need / opportunity to broaden scope of virtual ward provision

Further transformation to be planned in this area:

Over the next two years
- Develop a sustainable model of care for virtual wards
- Join the virtual wards with existing pathways to maximise admission avoidance and early supported discharge
- Work with digital teams to understand how to maximise benefits with tech enablement

Over years three to five
- Broaden scope and capacity within UCR and Virtual wards
- Integration with Neighbourhoods & proactive care model to maximise prevention

Programme funding:
- Ageing Well & Virtual Ward service development funding
- Existing service budgets

Leadership and governance arrangements:
- C&H Place Based Partnership Delivery Group and Health and Care Board
- NEL Community Based Care Programme Board / Community Health Collaborative

Key delivery risks currently being mitigated:
- Insufficient suitably qualified workforce to deliver new models
- Insufficient funding to deliver complex model
- Cost of living pressures – impact on delivery of care in the home environment
- Risk of digital exclusion as models develop and become more reliant on technology to support delivery

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Cardiovascular Disease Prevention / Redbridge Place based Partnership / Tracy Rubery, Borough Director (tracy.rubery@nhs.net)

The benefits that Redbridge residents will experience by April 2024 and 2029:

By 2024

- Utilise PHM to articulate risk factors and classification for CVD at Place
- Identify demographic risk modifiers for every individual registered in primary care
- Improve early detection of CVD especially of people with *high risk conditions*
- Population-level approaches to cardiovascular disease: *physical activity; smoking and tobacco use, alcohol, environment, air pollution and climate change*
- Risk management of disease-specific cardiovascular disease: *hypertension, coronary artery disease, heart failure, chronic kidney disease, atrial fibrillation, multimorbidity*

By 2029

- Leverage analytics/algorithms and visualisation tools to understand, track and report on population activity and measure improvements
- Greater peer led community support and engagement to enable self-care and lower acute care utilisation
- >85% of expected number of people with AF are identified; >90% of patients with AF who are already known to be high risk of stroke adequately anticoagulated
- >80% of the expected number of people with high blood pressure are diagnosed; >80% of the total number of people already diagnosed with high blood pressure are treated to target as per NICE guidelines
- >75% of people aged 40 to 74 have received a formal validated CVD risk assessment and cholesterol reading recorded on primary care data system in the last five years; >45% of people aged 40-74 identified as having a 20% or greater 10-year risk of developing CVD in primary care treated with statins; >25% of people with familial hypercholesterolaemia (FH)

How this transformation programme reduces inequalities between Redbridge's residents and communities:

- Getting upstream of cardiovascular disease, maximising condition identification, referrals and first outpatient attendance. This will include a differential focus on hypertension, diabetes, coronary heart disease, chronic kidney disease and atrial fibrillation.
- Removing the practical barriers that hold back some residents from seeking and ensuring their uptake of individual or population interventions
- Seeking to appropriately compensate voluntary community sector providers by recognising the increased costs associated with working with more deprived communities and by removing the financial barriers to residents taking up care options (for example, loss of benefits whilst in care or recovering from ailment).
- Improving the quality of patient-health professional decision-making and addressing digital exclusion, so that access virtual care, digital reminders and using algorithms to prioritise waiting times

Key programme features and milestones:

- Governance at Place from 2022/23 and forward, including sustained reporting at "End -to-End Pathways Working Group (COCWP)

Further transformation to be planned in this area:

- Over the next two to five years
  - ➢ Development of CVD dashboards that provide actionable insights
  - ➢ Scoping opportunities for standardising access and delivering care from 'Cradle to Grave' including community health, public health.

Programme funding:

CVD Prevention interventions

- Unknown

Leadership and governance arrangements:

- Level 1: Place based Partnership

Working groups established – CVD Prevention .

- Level 3: NEL Cardiac Clinical Network; NEL Renal Clinical Network, NEL Respiratory Clinical Network

Key delivery risks currently being mitigated:

- No available funding dedicated to CVD Prevention interventions

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Perinatal Mental Health Improvement Network / MHLDA Provider Collaborative / Pauline Goffin, Director of Mental Health, Learning Disabilities and Autism, NHS NEL, pauline.goffin@nelft.nhs.uk

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Improved access to specialist perinatal and maternal mental health services (8.76% by March 2024)
  - X additional peer support workers established within perinatal services across NEL
- April 2026:
  - Improved access to specialist perinatal and maternal mental health services (10.1% by March 2026)
  - Whole-pathway review completed as part of Perinatal Provider Collaborative development

How this transformation programme reduces inequalities between north east London's residents and communities:

- More support for women, pregnant people and partners throughout the perinatal period in every borough in north east London
- Increased availability of peer support workers, promoting access for underserved communities, and expanding our workforce so that is more representative of the communities we serve
- Through our improvement network approach, we are harnessing clinical and service user leadership, and using quality improvement and population health management tools to understand and address inequities in outcomes and experience for people with intersecting protected characteristics

Key programme features and milestones:

- Perinatal Improvement Network established – led by clinicians and service users – to promote and spread best practice, and drive service design and transformation
- *If approved* completion of due diligence and mobilisation work to transfer perinatal specialised commissioning responsibilities for the population to a NCEL Perinatal Provider Collaborative (hosted by ELFT) by October 2023
- Service user-led review of peer support workers within perinatal mental health services completed by Dec 2023 (interdependency with Lived Experience Leadership Programme)
- Review and refresh of maternal mental health services (specialist psychological interventions) by March 2024

Further transformation to be planned in this area:

Over the next two years

- Delivery of the requirements of the NHS Long Term Plan as regards perinatal mental health

Over years three to five

- If NCEL Perinatal Provider Collaborative is financially viable, there will be further longer-term opportunities for improving the join up and interrelation of services across the entire perinatal mental health pathway

Programme funding:

- 2023/24 funding for perinatal mental health TBD (from MHIS / SDF)
- Potential funding associated with transfer of perinatal specialised commissioning budget: £4.8m

Leadership and governance arrangements:

- Perinatal Mental Health Improvement Network to lead
- Reporting into MHLDA Collaborative Committee
- NCEL Perinatal Collaborative governance arrangements TBC

Key delivery risks currently being mitigated:

- The transfer of the specialised commissioning perinatal mental health responsibilities to a local provider collaborative may be financially risky as the envelope is small. This is being mitigated through a thorough due diligence process.
- NHS long term plan delivery risks (i.e. non-compliance with national targets) are being mitigated through the development of the Improvement Network and greater collaboration between services across NEL

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care		High-trust environment	x
Long-term conditions		Employment and workforce		Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

IAPT Improvement Network / MHLDA Provider Collaborative / Dan Burningham, Programme Director - Mental Health, NHS NEL dan.burningham@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2025:

- April 2024:
  - 28.9% of people with common mental health conditions accessing talking therapies by end-March 2024
  - Increased availability of NICE-recommended group based interventions across NEL
- April 2025:
  - 30% of people with common mental health conditions accessing talking therapies by end-March 2025 (pending funding settlement)
  - Increase in access to talking therapies for people with long term conditions

How this transformation programme reduces inequalities between north east London's residents and communities:

- The IAPT Improvement Network is focused specifically on increasing access to talking therapies for people in every borough across NEL, harnessing clinical and service user leadership to spread best practice and improve outcomes and experience, and to improve value
- Our IAPT Improvement Network will also have a specific lens on health inequalities, and will be hosting a Population Health Fellow to help us to systematically understand which groups (e.g. people with LTCs, older adults, black men) are underserved by talking therapy services, and using QI tools and techniques to improve access, experience and outcomes for those groups

Key programme features and milestones:

- IAPT Improvement Network is operational and leading the programme of work in partnership with place leads. The Network is led by clinicians and experts by experience
- New workstream focusing on increasing productivity across all IAPT services will be established, with clear plan in place for enhancing service productivity across NEL by September 2023
- New workstream focusing on addressing inequities in access and experience, led by a Population Health Fellow, will be established with clear work plan in place by December 2023
- Work to understand additional growth required to achieve 30% access target (taking account of any productivity gains) completed by March 2024

Further transformation to be planned in this area:

- Over the next two years
  - To be populated following IAPT Network Away Day on 3rd March 2023
- Over years three to five
  - To be populated following IAPT Network Away Day on 3rd March 2023

Programme funding:

- In 2023/24 this programme will be delivered at cost to providers – all funding is going towards expanding and improving IAPT services rather than programme delivery

Leadership and governance arrangements:

- IAPT Improvement Network to lead
- Reporting into MHLDA Collaborative Committee and to place-based partnerships re: local performance

Key delivery risks currently being mitigated:

- NHS long term plan delivery risks are being mitigated through the development of the Improvement Network and greater collaboration between services across NEL
- In some boroughs reduced access has been caused by high numbers of staff vacancies. Through focused efforts to increase recruitment and retention, and work across the Improvement Network to harness mutual support, these are largely mitigated for 2023/24

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	x	Health inequalities	x	Personalised care		High-trust environment	x
Long-term conditions	x	Employment and workforce		Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Improving health outcomes and choice for people with severe mental illness / MHLDA Provider Collaborative / Dan Burningham, Programme Director - Mental Health, NHS NEL dan.burningham@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - 60% of people receive an annual physical health check across NEL
  - 1000 active users of Patient Knows Best across NEL (patient-held record)
  - 300 additional personal health budgets for people with SMI
- April 2026:
  - 70% of people receive an annual physical health check across NEL
  - 2000 active users of Patient Knows Best across NEL (patient-held record)
  - SMI physical health outreach offer available in every borough for high-risk patients

How this transformation programme reduces inequalities between north east London's residents and communities:

- By focusing on the physical health needs of people with severe mental illness, we will be working to directly reduce the mortality gap between this group and the wider NEL population (which began to increase during the pandemic)
- The emphasis on targeting high-risk service users (people with SMI who are infrequent users of primary care and/or have never received a health check) through new culturally sensitive community outreach services will address health inequities driven through structural inequalities, particularly for minoritised communities across NEL

Key programme features and milestones:

- Supporting the work led by place-based mental health partnerships and teams to increase the uptake of SMI physical health checks; sharing best practice and learning from new and novel approaches
- Supporting the design and implementation of outreach approaches targeting high-risk service users, requiring culturally competent and sensitive approaches to tackling stigma and structural inequalities
- Supporting places to implement the patient-held record, known as Patient Knows Best (PKB), giving service users greater agency and control over their care plan
- Supporting places to increase the number of personal health budgets for people with serious mental illness, sharing best practice and learning from elsewhere

Further transformation to be planned in this area:

- Over the next two years
  - Increased role for Lived Experience Leaders in driving the Personalisation agenda
  - Closer collaboration with the VCSE on community outreach
- Over years three to five
  - NEL-wide digital mental health offer to support and underpin the use of PKB and personal health budgets

Programme funding:

- £1,735,000 non-recurrent funding from SDF and MH slippage (personal health budgets)
- £210,000 TBC (Patient Knows Best)

Leadership and governance arrangements:

- Led within places, supported by the MHLDA Collaborative programme
- Reporting into MHLDA Collaborative Committee and to place-based partnerships re: local performance

Key delivery risks currently being mitigated:

- There are issues with the integration engine to enable bi-directional data flows between trust records and Patient Knows Best. However, work is currently underway with digital leads to resolve this.
- There is currently a lack of lived experience leadership in these workstreams. The resources allocated to establishing the NEL Lived Experience Leadership Programme will mitigate this throughout 2023/24

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce		Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Improving outcomes and experience for people with dementia and their carers / MHLDA Provider Collaborative / Dan Burningham, Programme Director - Mental Health, NHS NEL dan.burningham@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - All places across NEL are compliant with the 66.7% dementia diagnosis rate
  - Dementia pathways in every place are comprehensively mapped with opportunities for improvement identified, including greater collaboration with the VCSE
- April 2026:
  - Improved access to evidence-based treatment and support in every borough
  - Reduction in preventable admissions to hospital for people with dementia
  - Increase in number of dementia carer assessments in every place across NEL

How this transformation programme reduces inequalities between north east London's residents and communities:

- Opportunity to share learning between places and explore opportunities to expand on good practice, including the award-winning models of care in Hackney that provide people with a continuous and consistent source of support from dementia diagnosis, all the way though to end of life
- To ensure that evidence-based support and treatment is available in all places, including (but not limited to); cognitive stimulation therapy, psychological therapy and signing for the brain
- By systematically understanding unwarranted variation in diagnosis rates for different communities, and developing culturally competent approaches to reducing inequity and tackling stigma

Key programme features and milestones:

- Establish a Dementia Improvement Network, led by lived experience leaders and clinical and care professionals, including social care
- Use the clinical expertise across the Network to understand immediate opportunities for improving the dementia diagnosis rate, including any digital solutions, by June 2023
- Lived Experience Leaders to identify key opportunities for improving support to carers by September 2023
- Deliver improvements in dementia diagnosis rate in every borough by March 2024
- Undertake comprehensive dementia pathway mapping in each place to understand existing service provision and any gaps / inequities between places by April 2024

Further transformation to be planned in this area:

- Over the next two years
  - Increase the number of peer support roles involved in dementia support services, including for carers
- Over years three to five
  - Explore opportunities to build on our existing relationships with academic institutions to lead our own research projects on dementia prevention

Programme funding:

- There is no resource currently allocated to delivering this programme

Leadership and governance arrangements:

- We would establish a new Dementia Improvement Network to lead in conjunction with place-based teams
- Reporting into MHLDA Collaborative Committee and to place-based partnerships

Key delivery risks currently being mitigated:

- Dementia sits in multiple portfolios (e.g. primary care, frailty, mental health, end of life, planned care, social care) which means that there is a lack of clarity across places and the system on leadership and improvement goals. This risk could be mitigated through the resourcing and establishment of a NEL wide-programme, led by the MHLDA Collaborative, with strong links into place-based partnerships and other provider collaboratives and ICS workstreams

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce		Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Crisis Improvement Network / MHLDA Provider Collaborative / Jamie Stafford, jamie.stafford@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2025:

- April 2024:
  - Reduction in proportion of 12 hour waits in emergency departments for all ages
  - Crisis alternatives operational in Waltham Forest and Barking & Dagenham
  - Reduction in system-wide bed occupancy to below 92%
- April 2025:
  - NHS 111 press 2 for mental health available across all places in North East London
  - Demonstrable progress with engaging the VCS in developing our crisis prevention approach
  - Reduction in S136 activity by 10%

How this transformation programme reduces inequalities between north east London's residents and communities:

- We will reduce unwarranted variation in 12 hour waits for people with mental health needs who attend emergency departments (with a focus on King George's and Queens Hospitals)
- Working to address the over-representation of black men being detained for mental health treatment through better join-up with the voluntary & community sector, and focusing on prevention
- Rolling out NHS 111 press 2 for mental health so that everyone can have easier access to mental health support
- Ensuring that crisis alternatives are available in every borough across NEL (including crisis houses and crisis cafes)

Key programme features and milestones:

- Crisis Improvement Network set up by April 2023 (with service user-led Think Tank established) to drive strategic redesign and develop creative approaches to prevention
- Review of Psychiatric Liaison Services across NEL completed, with recommendations for service improvements completed by September 2023 (including opportunities to make them all-age)
- Additional bed capacity brought online and operational by October 2023 (in preparation for winter)
- First roll-out of NHS 111 press 2 for mental health by end of March 2024 (may be staggered by geography)
- Work undertaken with Lived Experience Leaders and VCSEs to explore crisis prevention in the context of key health inequalities, with investment plans by April 2024

Further transformation to be planned in this area:

- Over the next two years
  - Increase no. peer support workers in crisis services
  - Closure of s.136 suite at Newham Centre for MH
  - Review and potential expansion of MH joint response cars
- Over years three to five
  - Review and redesign of crisis alternatives across NEL
  - Lived Experience-Led crisis service developed

Programme funding:

- TBC – pending finalisation of financial planning

Leadership and governance arrangements:

- Crisis Improvement Network to lead programme of work
- Reporting into MHLDA Collaborative Committee and NEL UEC Boards as required

Key delivery risks currently being mitigated:

- Data has been inconsistent and unverified, making it difficult to quantify and understand the problems we need to solve. Work underway with ICB data team and trust BI leads to develop common view of performance
- System-wide bed occupancy continues to be high, due to increased lengths of stay. Work underway to increase acute bed capacity to ease inpatient pressures and reduce waiting times. Also linking with places to maximise discharge pathways and step-down

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care		High-trust environment	x
Long-term conditions		Employment and workforce		Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Children and Young People's Mental Health Improvement Network / MHLDA Provider Collaborative / Carys Esseen, carys.esseen@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2025:

- April 2024:
  - 24,322 children and young people accessing mental health support across NEL
  - Roll-out of Intensive Community CAMHS Services (ICCS) across INEL
  - 95% of referrals to eating disorder services seen within 1 week (urgent) or 4 weeks (routine)
- April 2025:
  - 25,000 children and young people accessing mental health support across NEL
  - Talking therapies for anxiety and depression expanded to include 16 and 17 year olds
  - Model for mental health crisis alternatives for children and young people developed

How this transformation programme reduces inequalities between north east London's residents and communities:

- Increasing access to support for children and young people (CYP) in every borough across NEL, with additional resources diverted to support those boroughs with the greatest unmet needs
- Broadening offer of support across NEL with a greater emphasis on wellbeing, prevention, targeted support, support to parents / carers, and culturally competent care
- This programme links closely with the LDA Improvement Programme, the Crisis Improvement Network and the Babies, Children and Young People's programme to ensure that the intersecting needs of children and young people are considered, and that the specific needs of children and young people are considered in different service settings e.g. A&E

Key programme features and milestones:

- CYP Mental Health Improvement Network is operational and leading the programme of work in partnership with places and other programmes e.g. BCYP. The Network is led by clinicians and experts by experience
- Coproduction event planned for April 2023 to support the development of Lived Experience Leaders in CYP
- CYP Mental Health and Emotional Wellbeing Delivery Plan published in 2023/24 (timelines TBC), covering inequalities, workforce and iThrive implementation
- Expansion of ICCS across City and Hackney and Tower Hamlets so that there is full NEL coverage by March 2024
- Crisis alternatives codesigned with service users and carers and plans developed by March 2025
- Expansion of talking therapies to 16/17s by March 2025

Further transformation to be planned in this area:

- Over the next two years
  - Social prescribing plan for CYPs developed in line with iThrive principles with service users
- Over years three to five
  - Comprehensive digital offer underpinning NEL mental health and emotional wellbeing approach
  - 100% coverage of mental health and emotional wellbeing support in schools via MHSTs or equivalent

Programme funding:

- £4,345,000 for 2023/24 from CAMHS SDF
- Programme leadership resource TBC (this is non-recurrently funded by NEL ICB)

Leadership and governance arrangements:

- Led by the CYP Mental Health Improvement Network and place-based teams
- Reporting into MHLDA Collaborative Committee, BCYP Programme and place-based partnerships

Key delivery risks currently being mitigated:

- NHS long term plan delivery risks are being mitigated through the development of the Improvement Network, greater collaboration between services across NEL and Service Development Funding (however, there may still be a gap)
- There is currently a full-time programme manager supporting this work, funded by the ICB non-recurrently. There is no clarity on longer term resource available.

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions		Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Mental Health/ City and Hackney/ Dan Burningham, Programme Director - Mental Health, NHS NEL dan.burningham@nhs.net

The benefits that City and Hackney residents will experience by April 2024 and April 2026:

- April 2024:
  - 2000 co-produced digital personalised mental health care plans
  - 25% reduction in high risk people with SMI without a physical health check
- April 2026:
  - 3,000 co-produced digital personalised mental health care plans
  - 75% reduction in high risk people with SMI without a physical health check.

How this transformation programme reduces inequalities between north east London's residents and communities:

- People with SMI have a health inequality gap of 10-15 years reduced life expectancy.
- By 2026 3,000 more people with SMI will have access to their own health data and personalised co-produced health improvement goals
- By 2026 the number of people with SMI who have not had a physical health check will have been halved through our SMI outreach programme aimed at reaching under served and marginalised groups.

Key programme features and milestones:

- Physical health checks identify health risks early allowing lifestyle changes and medical interventions to be made to prevent deterioration.
- Co-produced care plans support personalised health improvement linked to physical health checks.
- Milestone 1: establishment of SMI outreach teams in all 8 PCNs by April 2025. Recruitment: 4 WTE HCAs
- Milestone 2: PKB digital platform accessed by all SMI HCAs and mental health community teams by April 2025.

Further transformation to be planned in this area:

- Over the next two years
  - Personalised care plans will be supported by health coaching and access to peer support
  - More psycho-educational materials will support patients
- Over years three to five
  - Personalised care planning will become more interactive through bi-directional feedback

Programme funding:

- SMI outreach: £240K workforce (MHIS)
- Digital care plans (PKB contract NEL wide funding)

Leadership and governance arrangements:

- SMI physical health improvement network
- PHR NEL Programme Board
- City and Hackney Mental Health Integration Committee

Key delivery risks currently being mitigated:

- Failure to recruit – plan early
- Teams do not adopt because of other priorities – ensure organisational leaders are on board and the operational level are engaged, informed, inspired and trained

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Adult Mental Health / Newham Place-Based Partnership / Richard Fradgley, Executive Director of Integration, ELFT rfradgley@nhs.net

The benefits that Newham's residents will experience by April [2024] and April [2026]:

- April 2024:
  - Culturally appropriate approaches and services in place
  - Increased opportunities for peer support, lived experience and employment
  - Improved care provision and experience of services
- April 2026:
  - X
  - X
  - X

How this transformation programme reduces inequalities between north east London's residents and communities:

- By identifying and agreeing priorities that are locally focussed based on data and evidence
- By focussing on universal to specialist level of needs using population health management approaches
- By having a strengthened focus on equity, equality and challenging racism and all forms of discrimination
- By working with and across all system partners, with a strengthened focus on residents voice from the start of any project

Key programme features and milestones:

- April 2023 – Agree a small number of initial priorities for partners to work together to deliver better outcomes for residents, staff and the system
- Develop and integrate our services including Supported Living, Rehab & Complex Care pathways
  - Forensic Step Down
  - High Needs / Residential Care
  - Supported Living Quality Standards
    - Develop and deliver a Recovery College service

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Adult Mental Health Partnership Board chaired by the Clinical Lead and a resident, which reports up to the Newham Health and Care Partnership Board and NEL MHLDA Committee

Key delivery risks currently being mitigated:

- X
- X

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Mental Health – living well programme / Havering / Luke Burton, Borough Director, luke.burton1@nhs.net

The benefits that Havering residents will experience by April 2024 and April 2026:

Mental Health - by April 2024:
- Will be able to access three new local mental health and wellness teams
- For residents with acute mental health needs who require inpatient care they will be admitted to more local units rather than being placed out of borough
- For those residents with severe mental illness, they will be supported to find and retain employment through the launch of the Individual Placement Support service
- Improved access to perinatal mental health services with increased access for local woman and their families
- Patient will have faster access to dementia diagnosis services with improved pre and post diagnostic support
- Suicide prevention – Provided with enhanced prevention support for those at high risks of suicide and self-harm

Mental Health – by April 2026:
- Faster access to early intervention services for those experiencing psychosis due to increased investment in Early Intervention team workforce capacity
- Crisis Services – access to improved 24/7 crisis response services
- Access to crisis lines through a new Single Point of Access (SPA) and timely, universal mental health crisis care through the development of a bespoke 111 Service
- Crisis Alternatives - Increased and improved alternative forms of provision for those in crisis e.g. sanctuaries/safe havens; crisis houses; crisis cafes
- Physical Health – improved physical health checks and access to interventions, through increasing the volume and quality of Serious Mental Illness (SMI) Physical Health Checks
- Expanded access and availability of IAPT (Improved Access to Psychological Therapy) provision for those experiencing Long Term Conditions i.e. due to long covid
- Improving access and outcomes for BAME (Black, Asian and Minority Ethnic) residents using talking therapies through targeted support

How this transformation programme reduces inequalities between north east London's residents and communities:
- Improving health checks for those diagnosed with a serious mental illness is one of the health inequalities listed in the Core 20 Plus 5 national health inequalities programme, through improving our local offer we aim to exceed the national target of 60% of those living with an SMI receiving their annual health check
- Traditional services and pathways do not work well for those with mental health issues, for example a standardised stop smoking service model shows poor quit rates amongst those with mental health, by commissioning tailored stop smoking services for those with mental health this reduces the inequalities a standardised model creates, a number of improvements to dementia pathways, local mental health and wellness teams, perinatal services and crisis services are all being made to help create equity.

Key programme features and milestones:
- Commission a specialist provider to deliver SMI Physical Health Checks by Dec-23
- Ensure 70% of SMI patients receive an annual health check by Mar-24
- Ensure dementia diagnosis rate is at least 66.7% by Mar-24
- Launch new Havering Dementia Strategy by Dec-23
- Develop local psychological therapy pathways and services for complex patients with EUPD (Emotionally Unstable Personality Disorder) by Mar-23.

Further transformation to be planned in this area:

Over the next two years
- ➢Further improvements to suicide prevention services
- ➢Further improvement to perinatal mental health services

Programme funding:
- ➢Funding is under discussion as part of SDF and MHIS
- ➢Funding for SMI PHCs for 23/24 is around £129k awaiting confirmation from NEL SMI PHCs Delivery Group

Leadership and governance arrangements:
- Work overseen by Havering Mental Health Delivery and Oversight Group – accountable to Havering Place Based Partnership Board

Key delivery risks currently being mitigated:
- Finance is a significant risk to the mental health programme due to system pressure in urgent & emergency care
- Workforce significant risks as recruitment to the mental health roles are very hard to recruit to due to lack of available skilled workforce

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions		Employment and workforce	X	Prevention	X	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Mental Health / Warwick Tomsett, Borough Director, Warwick.Tomsett@towerhamlets.gov.uk

The benefits that Tower Hamlets residents will experience by April 2024:

- A reduction in health Inequalities in terms of access, experience and outcomes
- More paid employment opportunities for people with mental health needs, including *people participation* as a route into paid employment
- A more preventative approach to mental health conditions
- Improving neurodevelopmental pathways, ensuring that people with ADHD and Autism have improved outcomes and experience
- Improved experience and outcomes for young people transitioning to adult services, including a more preventative approach to supporting them into adulthood

How this transformation programme reduces inequalities between north east London's residents and communities:

- Addressing and improving employment outcomes for those with mental health conditions and/or requiring mental health support
- Addressing and improving inequalities in access, experience and/or outcomes of mental health services where these exist
- Improving outcomes and experience for those with **ADHD** and **autism**
- Supporting young people with mental health conditions and/or requiring mental health **support transition into adulthood** with the required level of support

Key programme features and milestones:

- Creating paid employment opportunities for people with mental health needs, including people participation as a route into paid employment
- Improving the experience and outcomes for young people transitioning to adult services, including thinking about a more preventative approach to supporting them into adulthood
- Improving neurodevelopmental pathways, ensuring that people with ADHD and Autism have improved outcomes and experience
- Deep dive to understand the specific communities / characteristics of people impacted by:
  - premature mortality for people with SMI
  - poor health expectancy for women
  - cost of living crisis

Further transformation to be planned in this area:

- Over the next two years
  - Develop a plan to ensure key programmes are delivered
  - Identify further preventative approach and link more with TH public health team

Programme funding:

- Mental Health Investment Standard
- Core Based Funding from LBTH and ICB
- Better care Funds (BCF)

Leadership and governance arrangements:

- Principal strategic and operational oversight by Mental Health Partnership Board
- Monthly delivery oversight by Local Delivery Board
- Quarterly assurance monitoring at THT Executive Board

Key delivery risks currently being mitigated:

- Need to work up project and transformation plan as this is additional/new life course
- Gap in project governance and PMO support

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Mental Health / Waltham Forest / Sue Boon- sue.boon@nelft.nhs.uk

The benefits that Waltham Forest residents will experience by April 2024 and April 2026:

- April 2024:
  - Improved access to mental health interventions and support in localities through primary care
  - Their mental health needs will be considered holistically alongside their physical health, social care, housing and other needs
  - Improved experiences in health and social care of people living with Dementia
- April 2026:
  - We will reduce the health inequalities experienced by those who have MH support needs and/or who are homeless

How this transformation programme reduces inequalities between north east London's residents and communities:

- By linking with the evidence and action plan from the Marmot Review
- By making support and accommodation services more accessible for people who experience homelessness – by increasing outreach support
- By improving access to primary care, this will make MH support services more accessible to those who require them
- By supporting those living with dementia to access the right support in a way that suits them

Key programme features and milestones:

- Action plan development following Marmot Review
- Development of the MH primary care liaison model

Further transformation to be planned in this area:

- Over the next two years
  - Alignment to 15 minute neighbourhoods and locality hubs
  - X
- Over years three to five
  - X

Programme funding:

- Investment and Innovation Fund for 23/24
- CC2H business case

Leadership and governance arrangements:

- Waltham Forest MH Transformation Board – sub group of the Place Based Partnership Board
- Link to NEL MH LDA Board

Key delivery risks currently being mitigated:

- Workforce – issues in both MH and Primary Care
- Increased demand and acuity for services
- Ability to invest long term in areas that will reduce inequality whilst still trying to meet acute demand

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions		Employment and workforce	X	Prevention	X	Co-production		Learning system	

Standard template: transformation in NEL

North East London Health & Care Partnership

Workforce/ NEL / Francesca Okosi, Chief People & Culture Officer, NHS NEL, francesca.okosi@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - We will deliver by April 2025 900 jobs in health and care to residents in NEL
  - All providers to agree to work towards gaining accreditation for London Living Wage
  - We will work with partners to develop roles and services that provide services out of hospital
- April 2026: To be confirmed
  - Establish a permanent hub for local population to access job opportunities in health and care (To be confirmed)
  - Methodology for planning and introducing new roles building on the learning from collaboratives and development of new services and approaches (St Georges)

How this transformation programme reduces inequalities between north east London's residents and communities:

- By providing employment opportunities to our local residents in our health and care organisations providing employment to ensure social mobility.
- By ensuring opportunity and development to our residents to reduce deprivation and health opportunities
- By providing career pathways for our staff to develop skills that deliver effective health and care to our
- By ensuring that all employers agree to commit and start accreditation to be a london Living Wage employer

Key programme features and milestones:

- June 2023 Recruitment Health Hub and Social Care Hub to be operational
- April 2024 900 starts in London Living Wage posts across employers in Health and Care
- April 2024 – Learning from Bank and agency and good practice examples highlighted, shared and adopted
- April 2024 - System-wide integrated high-level co-designed Workforce Strategy focusing on enabling system-wide workforce transformation at System, Place and Neighbourhood, to be signed off.
- April 2024 – Workforce Productivity activities to contribute to deliver of activity and finance requirements 2from 2022-23 operational plan

Further transformation to be planned in this area:

- Over the next two years
  - Develop five-year co-designed NEL ICS workforce strategy action plan to deliver system transformation and innovation workforce objectives, priorities and programmes
  - Shared workforce across health, technology starting with acute collaboratives, Care using collaboratives
  - Increase substantive posts within providers to reduce reliance on bank and agency and productivity
  - Build on Health and Care hubs to explore feasibility of training academies to support pipeline

Programme funding:

- Non recurrent, Funding from NHSE/Health Education England and GLA where fit against NEL priorities
- Funding redistribution as we move to new models of community care

Leadership and governance arrangements:

- To be confirmed SRO for specific areas of transformation
- NEL People Board, EMT and the ICB Executive

Key delivery risks currently being mitigated:

- No confirmed and recurrent funding to support workforce transformation and innovation
- No funding clarity for ARRs roles for in Primary Care
- Turnover rate increases due to ageing work population
- Burnout of health and care staff caused by increased workload and pandemic
- Mitigations Turnover and Burnout: Creation of a single NEL workforce offer including health and wellbeing, development and mobility

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce	X	Prevention		Co-production		Learning system	X

The transformation portfolio: digital infrastructure

North East London Health & Care Partnership

Level 0 – Infrastructure
Robust foundations and digital maturity

Major population growth of around 300,000 people over last 10 years with similar upward trend for the next 10 years, as well as the need to exploit new technology necessitates

- Maintaining a strategy of minimising the number of systems across NEL
  - Single appointment system across the 5 NHS Trusts to be considered
  - Moving towards a single provider of acute EPRs (£45m allocated for replacement of the EPR in BHRUT with Cerner Millennium)
  - Moving towards a single provider of General Practice Patient Record systems
  - Single provider of mental health systems (Access RiO)
  - Multiple community systems are in use across NHS and third sector providers
  - PCNs will use EMIS Clinical Services or TPP with Online Consultation tools to support Extended Services
- Key investments (£220m capital, £270m revenue over 5 years)
  - Circa £2.7m investment into Care Home and Home Care sectors to implement electronic care records
  - £43m for EPR developments across NEL, primarily BHRUT's move to Cerner Millennium and upgraded IT equipment which will:
    - improve accuracy of record keeping and recall within the trust, enabling patients to 'tell their story once'
    - enable efficient handovers and staff communication
    - promote ease of access to better co-ordinate care delivery
    - improve the availability, timeliness and quality of clinical data
    - support clinical decision making by reducing the need to check other systems for information
    - establish a patient record based on a single defined dataset, allowing better integration with specialist and partner organisations, e.g. creation of single acute specialty Patient Treatment Lists
  - Up to 6 Community Diagnostic Centres (two already open) to ease the burden on acute sites, increase overall capacity and provide more certainty for patients, who can undergo procedures in a more convenient environment
  - Maternity service digitisation (Homerton moving to Badgernet (£500k), others will evaluate and decide between it and Millennium) to improve information available to clinicians
  - Medium term move to cloud based telephony across primary care to facilitate collaboration across practices and PCNs
  - Implementation of shared digital image capture and real-time sharing to reduce unnecessary procedures after transfers and reduce storage costs
  - Network, cyber and end user device improvements (using VDI where practical) to improve staff experience and ease of access to information
  - Online registration for GP patients (complete)
  - Expanding the Electronic Prescription Service to outpatient services (£440k)
  - Change facilitators to support transformation of primary care services (£1.4m invested in 22/23)

The transformation portfolio: digital infrastructure

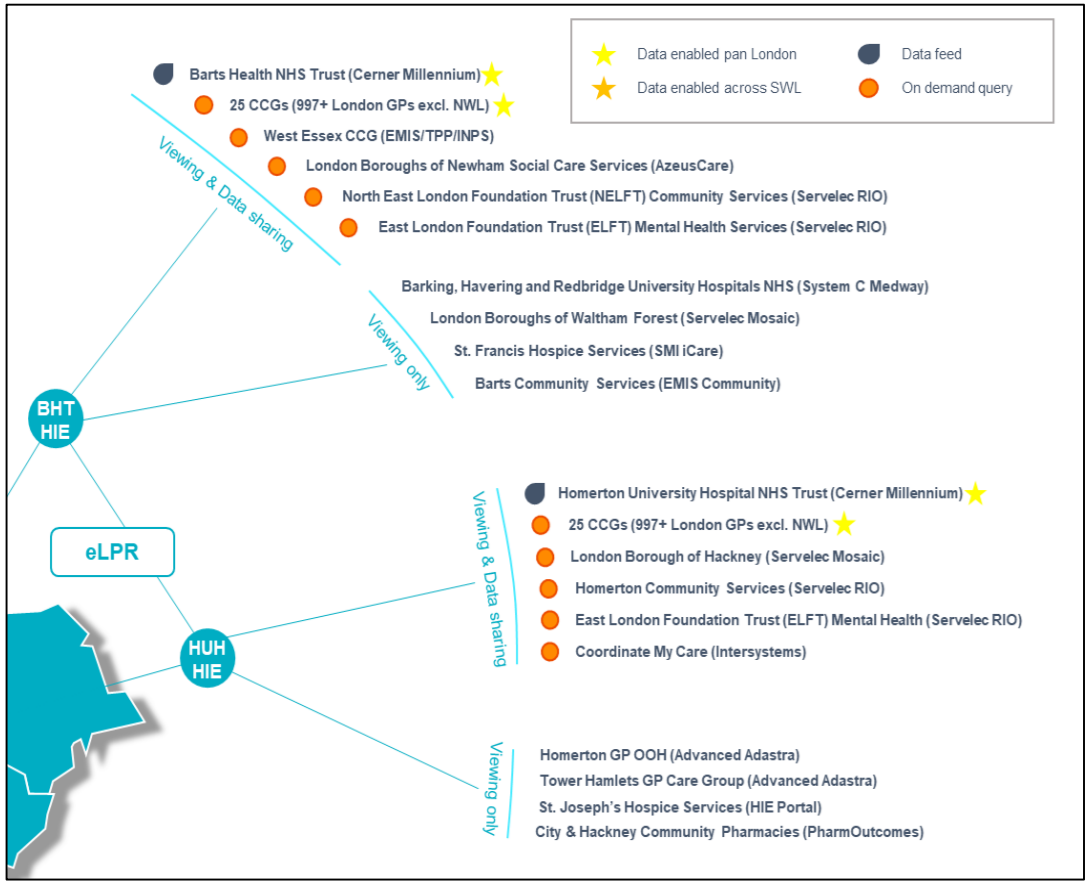
North East London Health & Care Partnership

Level 1 – Shared record
Single record

The vital importance of professionals having as complete a view of their patient's record as possible, means

- We will expand access to the Electronic Patient Record to:
  - the remaining social care providers
  - the remaining community pharmacists
  - all care homes with a secure electronic patient record systems (85% of Care Home providers are DSPT compliant)
  - the remaining community care providers with secure electronic patient record systems
  - independent sector providers with secure electronic patient record systems
  - the Joy social prescribing system currently being implemented in Newham and Barking and Dagenham.
- Key investments are needed (Total of £26m capital, £34m revenue over 5 years)
  - £2.5m invested for GP notes digitisation. Approximately £5m more required
  - £13m to improve the interoperability of systems in mental health and community and to support increased use by clinicians
  - £2.9m to complete the rollout of eLPR for BHRUT and three remaining Local Authorities

Access to east London Patient Record (eLPR) currently running at circa 350K views per month



east London Patient Record users, July 2022

The transformation portfolio: digital infrastructure

North East London Health & Care Partnership

Level 2 – Population Health / Advanced Analytics
Realtime information for proactive care
Leveraging population information

The use of advanced analytics and exploitation of the 'big data' that exists in NEL, is being, and will be, provided thus:

- Discovery Data Service (DDS) is now delivered in-house by NEL ICB and hosted for the NEL/NWL/SEL ICS collaborative
- NEL ICB will host the London Data Service, provide ICS partners with pan-London NHSD data sets and work with partners to develop a linked "data services layer" for all of London including acute, primary, community and social care data
- Implementation of the Cerner HealtheEDW in NEL will support professionals providing more proactive care to patients and contribute to a research data hub for London
- Further implementation of DDS Dashboards for Primary Care across NEL
- Utilise CORE25 plus 5 methodology to target and organise health and care interventions to improve outcomes, drive self care and reduce inequalities
- Rollout of the call/recall Active Patient Link tools for Childhood Immunisation and Atrial Fibrillation
- Key investments (£10.5m capital and £28.5m revenue over 5 years)
    - £14m for provision and future development of DDS
    - £6.5m in the data service within NEL to exploit DDS and other data sources
    - £5m within BHRUT for their internal data warehouse rebuild

The transformation portfolio: digital infrastructure

North East London Health & Care Partnership

Level 3 – Patient / resident engagement
Patient / resident empowerment

Improved resident and patient engagement will be achieved by

- Promotion of the NHSApp as the 'front door' to NHS services, including Patient Knows Best (PKB), primary care record, Online Consultations and ordering of repeat prescriptions
- Delivery of the Patient Held Record (PHR) PKB programme ('22-'24) to improve communication channels with patients and reduce unnecessary visits to hospital (Patient Initiated Follow Up)
- Greater use of online consultation tools in primary and secondary care to allow those that want to, to engage digitally and free up traditional channels for those that prefer to use them
- Management of Long Term Conditions in the home utilising remote care technology so reducing average length of stay and supporting people to remain in their own home rather than move to a care setting
- Co-production of digital solutions with end users, such as PKB
- Integration of physical health checks for residents with mental illness
- Further developing the Social Prescribing service by implementing Joy (initially in Barking & Dagenham and Newham)
- Increased use of digital tools to support elective recovery (including PIFU and advice & guidance) and reduced use of the unplanned health and care system
- Improving patient engagement further through digitisation in community pharmacy, care homes and domiciliary care providers

Much of this work will result in reducing the environmental impact of health and care services in line with the aims of the NELHCP Green Strategy

The transformation portfolio: physical infrastructure

North East London Health & Care Partnership

Standard template: transformation in NEL

North East London Health & Care Partnership

Critical Care / Acute Provider Collaborative / SRO: Simon Ashton, Chief Executive Officer, Barts Health simon.ashton@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Increased critical care capacity across the network (NUH, HUH, SBH)
  - Improved flow via joint working with the surge hub
  - Alignment of critical care outreach services across the network
  - Representing NEL patients at London and national forums to develop programmes
- April 2026:
  - Improved recruitment and retention of medical and nursing workforce
  - Improved access to specialist care
  - Equitable provision of follow up services across NEL which meet or exceed our London peers

How this transformation programme reduces inequalities between north east London's residents and communities:

- By 2026 patients will have equal access to specialist care, i.e. cardiogenic shock, and will be treated by a specialist team regardless of the hospital they present
- By 2028 patients will have access to a NEL specialist weaning centre, which will enable patients to receive weaning care in the local community, rather than having to travel out of the sector
- By 2026 patients will have equitable access to follow up services across NEL and in line with London, providing applicable patients with greater access to physical and psychological support following their admission in critical care.

Key programme features and milestones:

To develop a ratified strategy for adult critical care services across north-east London, develop a demand & capacity model that meets national Adult Critical Care network requirements and maximises potential opportunities to meet the future population needs and to develop and implement a medical workforce plan to support the current and future needs of critical care in NEL.

- Present final draft strategy to NEL Critical Care Board for approval and submission to APC (Dec 23)
- Agree standardised methodology and agree key data items and assumptions required to build capacity and demand model (Sept 23)
- Develop medical workforce strategy for NEL Critical Care Board approval (Oct 23)

Further transformation to be planned in this area:

- Over the next two years
  - Data sharing - patient records and operational information
  - NEL ACC Network website
  - Developing inter-site recruitment opportunities
- Over years three to five
  - Long term weaning centre
  - Renal enhanced care capacity
  - All units to work towards being GPICS compliant

Programme funding:

- 23/24: £250k – 67% funded via NHSE, remaining 33% to be funded by provider Trusts

Leadership and governance arrangements:

Programme lead: TBC

Programme overseen by NEL Critical Care Board and the SRO which reports to APC Executive Group.

Key delivery risks currently being mitigated:

1) Access to data - reliable data sources outside of critical care, i.e. population growth
2) Access to data across the APC provider Trusts
3) Resource – to enable delivery of the strategy and plan
4) Support at Trust level – would require agreement from all involved Trust
5) Trust integration – delivery will require integration of IT systems, and governance approach

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care	x	High-trust environment	
Long-term conditions	x	Employment and workforce	X	Prevention		Co-production	X	Learning system	

Standard template: transformation in NEL

North East London Health & Care Partnership

Research and clinical trials / Acute Provider Collaborative / SRO: Alistair Chesser a.chesser@nhs.net

The benefits that north east London's residents will experience by April 2024and April 2026:

- April 2024:
  - Increased and more equitable access to clinical trials across NEL
  - Research activity and clinical trials will cover a broader range of services
  - Increased patient and public involvement and engagement (PPIE) in clinical research
- April 2026:
  - Increased volume and quality of clinical research will support service quality improvement
  - Increased focus on research themes that address health needs and inequalities in NEL
  - Outputs from clinical trials and research activity will be applied to improve service delivery

How this transformation programme reduces inequalities between north east London's residents and communities:

- By April 2024: PPIE programme will be established to engage local communities in the development of clinical research strategies
- By April 2024: Clinical trial participation will be extended to currently under-represented communities and patient groups
- By April 2026: Increase in participation in research and clinical trials across all groups, and participation gap between different communities will be reduced compared with current baseline
- By April 2026: Clinical trials outputs will address specific health needs for currently under-represented communities

Key programme features and milestones:

Purpose: the development of a strategy and workplan for the co-ordination and development of research and clinical trials across North East London (NEL)

- Development of shared policies and processes (Jul 2023)
- Assess scope of current research inequalities and develop action plan (Jul 2023)
- Increase access to clinical research training (Dec 2023)
- Strengthen academic links between Trusts and academic partners (QMUL, UCL, City, UEL, Greenwich) (Dec 2023)
- Develop and implement NEL approach to research PPIE (Mar 2024)
- Improve clinical trial recruitment processes (Mar 2024)
- Increase clinical trial income from commercial and non-commercial studies (Apr 2024)

Further transformation to be planned in this area:

- Over the next two years
  - Multi-site clinical trials across NEL
  - Flexible use of clinical research resources across NEL
  - Integrated research skills training programmes
- Over years three to five
  - Clinical trials facilities at each hospital site
  - Primary care and mental health research facilities
  - Development of clinical academic centres of excellence

Programme funding: (Overall sum and source; breakdown across capital, workforce / care services, programme delivery)
The programme resources are made up of personnel from the three trusts.

Leadership and governance arrangements:

Programme lead: Sven Bunn
Programme overseen by management group (PMG) which reports to APC Executive Group.
Working with LCRN and Trust Research Boards.

Key delivery risks currently being mitigated:

1) Overlap / conflicts with Trust level governance processes - Ensure specific role and tasks for the APC RCT workstream
2) Resource / time commitment - Clear work plan and outputs
3) Organisational commitment - Ensure alignment to strategic objectives

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production	X	Learning system	X

Standard template: transformation in NEL

North East London Health & Care Partnership

Specialised Services / Acute Provider Collaborative / SRO: Charles Knight, Chief executive Officer, Barts Health Charles.knight@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

April 2024:

A greater involvement of joining up specialise services with pathways within NEL, via specialise services being delegated to NEL ICB. Improvements to residents includes:

- Renal - Improved access to home therapies - by 2024 there will be an Independent Therapies Centre at Mile End Hospital (and a young person's unit) and by 2024 a Mosque dialysis Unit will be in place. Currently achieving target of 20% dialysis patients on home therapy - 78 patients either having haemodialysis at home, or in training to do so, with plans to increase this number.
- Haematology - Residents with sickle cell will receive appropriate analgesia and other pain management measures (ideally within 30 minutes) when attending any acute A&E in NEL
- Paediatrics – reduce waiting times and address variation across sites for surgery in children by implementing GIRFT principles across NEL

April 2026:

- Specialise services proactively working as part of end to end pathway transformation approach, with a aim to reduce residents attending specialise service with preventable conditions by improving prevention programmes in NEL and haulting the progression on LTCs
- Neonatal – increase cot capacity in NEL, along with improved Enhancing the experience of families through care coordinators and embed Family Integrated Care in all units
- Cardiac – implement the Cardiac Pathway Improvement Programme which a aim to improve quality and safety of care across the pathway leading to better outcomes
- HIV – residents are 50% less likely to die as a result of HIV/AIDs

How this transformation programme reduces inequalities between north east London's residents and communities:

- Providing care closer to home and reducing unwarranted variation across London by implementing new models of care for L2 and L3 paediatric critical care
- Delivering the Cardiac Pathway Improvement Programme (CPIP) to reduced mortality due to cardiovascular disease by reducing variation in prevention, detection and management of CVD risks
- Hep C – We are working with the Hepatitis C Trust to identify disadvantaged and vulnerable groups are at risk of hepatitis C, such as people who are homeless, undocumented migrants and sex workers to provide different options for testing such as opt out testing in A&Es and work with local communities to reduce sigma and open up the conversation regarding support.
- By reducing unwarranted variation in access to specialist assessment & treatment within 24 hrs of symptom onset for NEL residents with TIA (current range between 40% for BHR to 92% for C&H residents)

Key programme features and milestones:

From April 2024, NHSE will be delegating responsibility and budgets to NEL ICB for a number of specialised services. The team will ensure robust infrastructure to optimise the benefits and manage the risks of delegation in the short, medium and longer term through end-to-end pathway redesign & LTC management closer to the patient's home. The programme provides the opportunity to co-produce new models of specialist clinical care with specialist clinicians, networks and service users, to improve outcomes for patients, including:

- Establish 8 Rapid Access Acute Rehabilitation beds at the Royal London to improve patient outcomes and experience and reduce overall length of hospital stay by Q1 23/24
- All acute hospitals will provide HIV and Hep C & B opt out blood tests to 90% of those who attend ED by Q2 23/24
- Dialysis & Home Therapies: Independent Therapies Centre (ITC) at Mile End Hospital (building complete Q3 23/24

Further transformation to be planned in this area:

- Delegation from 24/25 is planned for c 59 specialised service lines which will incrementally increase, annually, as NHSE deem an increased number of services as suitable for delegation.
- Short term delivery is based on the priorities described; medium term levelling up clinical outcomes will be through acute collaboration, whilst in the longer term, service consolidation will drive a reduction in clinical inequality.

Programme funding:

- The delegated budget is c £597m with the potential for a further £32m to be rapidly delegated.

Leadership and governance arrangements:

- Director Archna Mathur; Programme Director Charlotte Stone
- Oversight & Assurance framework for specialised services (NHSE) and NEL specialised Service Programme Board.

Key delivery risks currently being mitigated:

- Funding formula changes disproportionately impact NEL and population-based allocations impact cross-border flows however pace of convergence safeguards for year 1 provide a mitigation
- Resources to deliver the specialised services programme are a key risk as the delegation is not accompanied by NHSE resource. Resource mitigations are however in place with a resource plan submitted for iCB consideration,

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Lived Experience Leadership Programme / MHLDA Provider Collaborative / Carys Esseen, carys.esseen@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - 50 adult mental health service users and carers across NEL upskilled and trained to act as Lived Experience Leaders (LELs)
  - Lived Experience Leaders active in all aspects of the MHLDA collaborative
- April 2026:
  - 150 (cumulative) service users and carers trained as LELs (including U18s)
  - Lived experience leadership approach expanded to include people with learning disabilities and autistic people, with resources secured to support this expansion

How this transformation programme reduces inequalities between north east London's residents and communities:

- Mental health service users and carers are supported to develop their skills and confidence; improving their quality of life and helping them to work towards employment (where desired)
- The priorities of our service users and carers relate strongly to reducing inequalities, improving cultural competence, and improving access to services for people across NEL
- This programme will explicitly reach out to users of non-NHS mental health services and ensure they have the same access to development opportunities as those in secondary care
- Lived Experience Leaders will bring fresh perspectives and creative approaches to tackling the challenges we face, including reaching out to underserved populations and communities

Key programme features and milestones:

- By May 2023 we will have recruited to our brand new Lived Experience Leadership Team roles, which will be prioritised for people with current or recent experience of using mental health services and their carers
- In late-2023 we will have a follow-up Mental Health Summit to review progress and strategic priorities
- By December 2023 we will have initiated work to develop our Lived Experience Leadership Programme to include autistic people, people with learning disabilities and their carers
- By April 2024 we will be able to point to and measure specific service improvements or other demonstrable outputs from projects or initiatives that Lived Experience Leaders have been supported to lead

Further transformation to be planned in this area:

- Over the next two years
  - Develop an approach to building leadership capacity in children and young people
  - Learn what matters most to autistic people and people with learning disabilities and their carers
- Over years three to five
  - Expand Lived Experience Leadership Team capacity to cover all ages, and LD and Autism

Programme funding:

- £117,000 in 2023/24 from growth in MH funding
- Staffing costs - £97,000
- Sundry costs - £20,000

Leadership and governance arrangements:

- Support from MHLDA Collaborative Exec, and ELFT & NELFT Patient Experience / People Participation leads
- Reporting into the MHLDA Collaborative Committee

Key delivery risks currently being mitigated:

- There is a lack of capacity within ELFT, NELFT and the ICB to match the ambitions of our service users and carers. This has been mitigated through the identification of resource to fund and support this work.
- There is a risk that this work remains limited to adults with mental health needs, but once the posts (above) have been recruited to, there will be capacity to support people with LD and autism, and children and young people

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care		High-trust environment	x
Long-term conditions		Employment and workforce	x	Prevention		Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Learning Disability and Autism Improvement Programme / MHLDA Provider Collaborative / Pauline Goffin, Director of Mental Health, Learning Disabilities and Autism, NHS NEL, pauline.goffin@nelft.nhs.uk

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Adult inpatient numbers to be below 30 per 1,000,000 population across NEL
  - Child inpatient numbers to be below 15 per 1,000,000 population across NEL
  - 75% annual LD health check target met or exceeded in every borough
- April 2026:
  - A consistent crisis pathway to be in place for all children and young people
  - Improved reasonable adjustments in mainstream health services (LeDeR recommendations)
  - Equitable access to community health support across all seven boroughs for the LDA cohort

How this transformation programme reduces inequalities between north east London's residents and communities:

- By ensuring that all mainstream health services are able to provide reasonable adjustments and the same level of service for residents with a learning disability and autistic residents
- By supporting all residents to receive assessment and diagnosis promptly, along with the necessary support following diagnosis
- By having a crisis pathway in place for children, young adults and adults with a learning disability and autistic people that emphasises proactive, personalised, and preventative support in the community, from integrated teams that can wraparound individuals and their families / carers

Key programme features and milestones:

- Led by NEL LDA Improvement Programme in collaboration with places, with clinical leadership from ELFT, NELFT and place clinical leads
- Implementation and mobilisation of the NEL key working service for children and young people – June 2023
- Mobilisation of expanded ASD pathway – June 2023
- Development of NEL Intensive Support Teams (IST) for adults – April 2024
- Increase uptake of health checks in 14-17 year olds, and conclude ASD health check pilot – April 2024
- Address gaps in community provision for people with an LD, including access to therapies – April 2025
- Implementation of crisis pathway for children – April 2025
- Consistent offer for autistic people of all ages – April 2026

Further transformation to be planned in this area:

- Over the next two years
  - Inpatient care and crisis support
  - ASD diagnosis pathway
  - Improving quality and uptake of annual health checks
- Over years three to five
  - Parity in community health support
  - Support and therapies for autistic people of all ages
  - Further development of CYP crisis support

Programme funding:

- £4.5 mil via SDF and the LDA Pathway Fund in 2023/24

Leadership and governance arrangements:

- Led by the NEL LDA Improvement Programme and place-based teams
- Reporting into MHLDA Collaborative Committee and to place-based partnerships

Key delivery risks currently being mitigated:

- Lack of capacity within programme team and at place to deliver on these ambitions. It is hoped this will be mitigated through the ICB restructure programme
- Lack of consistent approach to coproduction – funding apportioned to deliver this in 2023/24
- Temporary closure of sole LD inpatient ward – to be mitigated by introduction of IST model

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce		Prevention		Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Ageing Well/ Barking and Dagenham Place / Sharon Morrow, Director of Partnership, Impact & Delivery Barking and Dagenham, NHS NEL sharon.morrow2@nhs.net

The benefits that Barking and Dagenham residents who require proactive care will experience by April 2024 and April 2029:

- April 2024:
  - Greater access to wider activities in communities to improve health & well being
  - Fewer exacerbations of ill health and a better quality of life
  - Some new models of care that have been co-designed with residents
- April 2029:
  - Fewer residents moving from moderate to severe frailty
  - A reduction in non-elective activity due to chronic ambulatory care sensitive conditions
  - Providing services and support for residents to prevent development of health conditions and understand when and how to access services for the assessment and management of long-term conditions.
  - Improving health and wellbeing for residents, particularly those with long term conditions

How this transformation programme reduces inequalities between north east London's residents and communities:

- By addressing the impact of the wider determinants if health in the development of the model of care
- By building trust with residents, connecting them to community support, and engaging the voluntary sector and residents in co-designing services around residents
- By delivering a better resident experience by ensuring residents receive integrated and personalised health in places they choose to access, resulting in a better quality of life
- By reducing avoidable exacerbation of physical and mental ill health, including in underserved groups.

Key programme features and milestones:

To develop a new model of care across health, care and the voluntary sector that supports individuals in achieving their biopsychosocial and clinical goals.
Programme objectives are:

- To develop an MDT approach for people with mild/moderate frailty and co-morbidities (Q3 23/24)
- To connect disjointed parts of the system together by integrating PCNs with the VCSE through and emerging locality leads model (Q2 23/24)
- To establish a high intensity user service that meets best practice guidance, focussing help for non-medical factors as well as poor physical & mental health (Q3 23/24)
- To support carers identification training and carers support in line with the actions outlined within the Carers Charter (Q1 23/24)

Further transformation to be planned in this area:

- Over the next two years
  - Accelerate integrated care delivery at neighbourhood and place by using PHM to drive tangible change
  - Review the social prescribing model to optimise impact and integration with VCSE
  - Develop greater use of technology to support people living at home
  - Ensuring more residents with health conditions are assessed, identified and provided with condition management as early as possible.
- Over years three to five
  - Explore opportunities for integrating community hubs into the model
  - Providing support to enable independent living
  - Strengthening the NHS response to identifying and addressing domestic abuse

Programme funding:

- Ageing Well funding TBC (network roles)
- Health inequalities funding (localities model)
- Business case to be developed for HIU service

Leadership and governance arrangements:

- B&D Partnership Board
- B&D Adults Delivery Group
- B&D Executive Steering Group

Key delivery risks currently being mitigated:

- Programme resource not yet aligned to delivery plan – this has been included in ICB restructure; interim project capacity being explored
- Analytics support for PHM and data sharing agreements to be agreed
- PCN engagement and capacity to expand MDT working:

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production		Learning system	X

Some Ageing Well funding is allocated within the BCF

Transformation in NEL

North East London Health & Care Partnership

Healthier weight / London Borough of Barking and Dagenham Public Health / Dr Mike Brannan Mike.Brannan@lbbd.gov.uk

The benefits that Barking and Dagenham residents will experience by April 2024 and April 2028:

- April 2024:
  - Weight management services more tailored to needs and preferences of families
  - Improving coordination and coherence across workstreams and stakeholders
  - Development of a Tier 3 Weight Management Service pilot
- April 2028:
  - Integrated approach to healthier weight services that are appropriate and accessible
  - Greater promotion and access to healthier weight opportunities (e.g. physical activity, healthy diet)

How this transformation programme reduces inequalities between north east London's residents and communities:

- By ensuring those with an unhealthy weight are able to access support through weight management services that meet their needs and preferences
- By supporting and enabling more residents to consume a healthier diet (~1 in 2 adult residents not achieving '5 a day'; lowest in London)
- By supporting and enabling more residents to be more active (~1 in 2 adult residents not active enough for good health; second highest in London)
- By creating environments and opportunities to make healthy eating and regular physical activity the easy choice.

Key programme features and milestones:

Healthier weight requires action across the drivers of weight and their determinants, therefore work covers:

- *Assessment and weight awareness raising* - National Child Measurement Programme
- *Weight management services* - Tier 2 (0-5, 5-12, Adults), Tier 3 pilot (CYP; FY2023-25), CVD Prevention, NHS Digital weight management, Diabetes Prevention
- *Physical activity promotion* – Community programmes, Sport and leisure services, park services, Exercise on referral, School Games, Social Prescribing
- *Healthy diet promotion* – Food Education Partnership, Good Food Economy Action Plan
- *Healthier lifestyles* – Healthy schools programme, 0-19 Universal services, Holiday Activity & Food clubs, Eat Well, Live Well, Feel Great (SEND)

Further transformation to be planned in this area:

- Over the next two years
  - Expansion of whole systems approach across wider stakeholders
  - Better targeted/tailored and more integrated weight management services
- Over years three to five
  - Coherent approach to promoting healthier weight behaviours (activity, diet)

Programme funding:

- LBBD (Public Health Grant, Education)
- NEL ICB

Leadership and governance arrangements:

- B&D Partnership Board
- NCMP working Group
- BHR Health and Care Cabinet
- Whole Systems Approach to obesity working groups

Key delivery risks currently being mitigated:

- *Lack of coordination* – Greater collaborative working (e.g. NCMP working group) and cross promotion
- *Commercial determinants / obesogenic environment* – Focus on creating environments and opportunities to make healthier food and activity easier
- *Wider societal drivers (e.g. deprivation)* – Embed promotion and support for healthier weight behaviours across Place interventions

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health		Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Stop Smoking service (specialist and pharmacies] / Barking and Dagenham Place / [SRO and email address TBC]

The benefits that Barking and Dagenham's residents will experience by April [2024] and April [2026]:

April 2024:
- Improve recording of ethnicity data to ensure more accurate data on smokers
- Increase number of quitters year on, particularly in BAME men
- Reduction in rates in women,
- Minimise proliferation of Shisha outlets & illegal tobacco sales
- Reduction in vaping and shisha use in young people

- April 2026:
  - Reduction in smoking attributable hospital admissions and mortality
  - Accessible evidence-based stop smoking services
  - Reduce Illicit tobacco sales and smoking in people with MH issues
  - Trust built with residents by co-designing services with the residents

How this transformation programme reduces inequalities between north east London's residents and communities:
- By 2024, increase access to smokers from all communities including BAME and males who have a higher smoking prevalence.
- By 2025 reduce smoking in women, especially in pregnancy hence improve the child's best start to life.

Key program features and milestones:
LBBD has an inhouse service delivered by Comsol:
Level 3 specialist stop smoking service. Target groups
- COPD patients
- Pregnant women and partners
- Patients with diagnosed mental health condition.
- Young smokers aged 12-15
- Routine and manual workers.

The service offers holistic support to residents addressing the wider determinants, behavioural support and pharmacotherapy. Training for pharmacies. Working with the targeted lung screening programme to reach more males.
Level 1: London digital smoking service.
Trading Standards Team: on illicit tobacco & shisha use.
Targeted Lung Health Programme: scans offered to residents aged 55-75 years who have ever smoked.

Further transformation to be planned in this area:
- Over the next two years
  - Work with schools to implement NICE guidance on School-based interventions & link in with Healthy Schools work
  - Joined up working approach with Trading Standards.
- Over years three to five:
  - Deliver system wide approach to improve access by exploiting place-based arrangements e.g. engaging community champions, voluntary sectors
  - Broader work with local key stakeholders to work on Smokefree places and NHS

Programme funding:
- Overall sum and source: £400k
- Breakdown across capital, workforce / care services, programme delivery:
- Workforce £206k/programme delivery 194k

Leadership and governance arrangements:
- Director of Public Health
- Director of Community Participation & Prevention
- NEL NHS Tobacco Treatment Program Steering Group

B&D Partnership Board

Key delivery risks currently being mitigated:
Tobacco Control Partnership (that set local priorities) ceased in 2018/2019 due to staff changes.

Mitigation: service has developed other partnerships: ComSol, NELFT mental health services, BHRUT maternity services, primary care and adults drug service.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Estates / Barking and Dagenham Place / [SRO and email address TBC]

The benefits that Barking and Dagenham residents who require proactive care will experience by April 2024 and April 2026:

- April 2024:
  - Improved access to a wider range of community diagnostics
  - Better access to primary and community care service through the Beam Park Health Centre
- April 2026:
  - Access to one stop shops for health and care through integrated hubs in the community
  - Access to an integrated community, leisure and health hub for residents in the Barking Riverside area; improved access to primary

How this transformation programme reduces inequalities between north east London's residents and communities:

- By improving access to services closer to home
- By increasing capacity for more flexible, integrated service provision which enables care co-ordination and multi-disciplinary working across health, care and the VCSE
- By delivering a better resident experience through person centred estate that meets the needs of local communities

Key programme features and milestones:

To develop Barking and Dagenham infrastructure plan that will enable the partnership to deliver levels and quality of health and wellbeing services from sufficiently located, sized, and equipped premises in the short, medium and longer term as the population grows. The programme includes:

- The development of a SOC for Barking Community Hospital and Town Centre
- The development of the Barking Riverside hub business case (NHS lease agreement Q3 23/24)
- Optimisation of Beam Park health centre estate (open spring 2024)
- Mobilisation of the new Community Diagnostic centre (Q3 23/24)

Further transformation to be planned in this area:

- Over the next two years
  - Procurement of the health centre at Barking Riverside
  - Infrastructure development to support neighbourhood networks/Fuller implementation
- Over years three to five
  - X
  - X

Programme funding:

- NHS capital funding
- Section 106 funding for health infrastructure

Leadership and governance arrangements:

- B&D Local Infrastructure Forum
- B&D Partnership Board

Key delivery risks currently being mitigated:

- There is insufficient internal resources to deliver the programme - business case for interim capacity to be developed
- Service models can't be agreed – ensure early involvement of clinical teams in the development
- Revenue to support new healthcare estate – work with the LA Regeneration and Planning teams to maximise the S106 contributions for health infrastructure

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Supporting our residents with Cost of Living pressures in City and Hackney /City and Hackney Place Based Partnership / Nina Griffith, Workstream Director, NHS NEL, nina.griffith@nhs.net

The benefits that City and Hackney residents will experience by April 2024 and April 2026:

- April 2024:
  - Easier access to services that can support people with cost of living pressures
  - Increased uptake of all benefits that are available to those individuals
  - Access to a wide range of vol sector support in the community
- April 2026:
  - Significant increase in proportion of benefits reaching eligible individuals
  - Residents that are struggling receive a proactive offer of support which meets their needs and supports them into a sustainable financial position
  - Fewer people becoming homeless

How this transformation programme reduces inequalities between north east London's residents and communities:

- By providing direct economic aid to people who are close to or living in poverty
- By preventing people from becoming homeless
- By supporting people who are most vulnerable to cost of living pressures because of existing health problems or disabilities

Key programme features and milestones:

- Hackney Money Hub fully mobilised and realising intended benefits – by Q2 23.24
- Sustainable model for money hub agreed - by end 23/24
- Food network and Advice networks well established across the borough – by Q2 23/24
- Learning from warm hubs taken forwards for future winters – Q2 23/24
- Ongoing programme of training to equip front line staff with key tools / support offers across all partners – Q2 23/24
- Clear framework / structure for neighbourhood based approach in place – end 23/24
- Broaden the approach to focus on employment – Q2 23/24

Further transformation to be planned in this area:

- Over the next two years
  - All staff equipped with tools to support residents with cost of living pressures
  - Outreach model that proactively provides support
  - Wide a range of support services in place
- Over years three to five
  - A range of easy to access and evidence based support offers that are fully integrated into our Neighbourhoods model and proactively outreach to those who need it most
  - Clear approach to support people into employment

Programme funding:

- Most of the funding is via existing service budgets.
- Some additional investment has been put in place:
  - £509k to fund the Money Hub- from S256 transformation monies
  - £50K to support our food networks from S256
  - Use of government benefits- including HSF

Leadership and governance arrangements:

- Cost of Living System group in place, led by Place Director. Reports into the Neighbourhoods Health and Care Board and the Hackney Corporate Leadership Team

Key delivery risks currently being mitigated:

- Money Hub is only funded via non recurrent funds
- Impact of cost of living far reaching and we have limited levers to support residents
- Fuel costs and inflation continue to rise
- Lack of sustainable funding for many of our voluntary sector partners

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	x	Health inequalities	x	Personalised care		High-trust environment	
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Population Health / City and Hackney Place Based Partnership / SRO is Sandra Husbands sandra.husbands@hackney.gov.uk. Operational leads: Anna Garner and Joia De Sa.

The benefits that City and Hackney's residents will experience by April 2024 and April 2026:

- April 2024:
  - Improved collection of inequalities data, enabling services to identify and tackle inequalities
  - Improved ability of services to tackle inequalities
- April 2026:
  - Services will recognise the need for support to be proportionate to need and thus services will be more accessible to those who need them.
  - Residents wider social needs will be identified and met via contact with and liaison between services.

How this transformation programme reduces inequalities between north east London's residents and communities:

- By Improving the ability of partners to use data to identify inequalities locally and put in place interventions to reduce these
- By Improving the ability of partners to include residents in identifying interventions to reduce inequalities – thus empowering residents and improving chances of these interventions being effective
- By Increasing focus on prevention and thus preventing ill-health for those with high needs (health and wider social)

Key programme big ticket items:

- Improving collection and use of equalities data across City and Hackney including development and implementation of an equalities data strategy.
- MATCH project (embedding health equity in City and Hackney) – development of package of support (tested with 6-7 areas) – using NEL inequalities funding (2022 round)
- Implementation of Prevention Investment Standard – increasing focus and resources to prevention across partners in C&H.

Leadership and governance arrangements:

- Population Health Hub planning board – chaired by Sandra Husbands as SRO
- Reporting to C&H PbP delivery group and Neighbourhood health and care board
- MATCH project steering group

Programme funding:

- £400K (from LBH Public Health) for staffing
- £1M for prevention project delivery

Key delivery risks currently being mitigated:

- Lack of capacity of partners to engage in population health planning or initiatives when focusing on waiting lists or other immediate capacity issues
- Lack of Population health hub team capacity to take on increased projects

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Standard template: transformation in NEL

North East London Health & Care Partnership

Neighbourhoods Programme / City and Hackney Place Based Partnership [hosted by Homerton Health Care] / Sadie King S.King33@nhs.net]

The benefits that City and Hackney residents will experience by April 2024 and April 2026:

April 2024:
- Residents feel understood, listened to and empowered to use their strengths
- Residents know where to go for help when they need it
- All residents feel that they have an accessible forum to have their voice heard in local service design or delivery

April 2026:
- Residents are more physically active and able to do the things they enjoy for longer
- Residents experience reduced loneliness and isolation
- Residents have the skills, knowledge and confidence to manage long term health conditions
- Residents are more socially connected
- Residents gain increased self-esteem and aspiration

How this transformation programme reduces inequalities between north east London's residents and communities:
- By embedding an anti racist mind set in service design and improvement (OD pilot in LTCs)
- By developing a network of community navigation that reaches groups that have experienced institutional discrimination
- By embedding skills and ways of working that puts resident voice at the centre of health and care provision
- By coproducing a personalised care approach
- By developing infrastructure and systems where community insights and population health data are used routinely to identify and address locally specific health inequalities

Key programme features and milestones:
- A new Proactive moderate frailty neighbourhood pathway
- Multi-Disciplinary Meetings for shared decision making for people living with complexity
- Neighbourhood Forums, and working groups bringing residents, voluntary and statutory sector together to share insights and find solutions to local health inequalities
- Community Navigation Networks
- A workforce development programme
- Key services structured around the 8 Neighbourhood geography: Community nursing, Adult Social Care, Community Pharmacy, Community mental health.
- Long term condition pathways development (Community Gynaecology)
- Outcomes Framework and Evaluation

Further transformation to be planned in this area:
- Over the next two years
  - Neighbourhoods local leadership infrastructure
  - Frailty pathways improvement from prevention to end of life.
  - Neighbourhoods Workforce development
- Over years three to five
  - Estates and IT enablement
  - LTCs pathways

Programme funding:
- Overall sum and source: currently 1 million £ per annum Better Care Fund
- Breakdown across capital, workforce / care services, programme delivery: All Programme Delivery.

Leadership and governance arrangements:
- City and Hackney Health and Care Board
- City and Hackney Neighbourhoods Health and Care Board
- City and Hackney Place Based Delivery Group
- Neighbourhoods Providers Alliance Group

Key delivery risks currently being mitigated:
- Workforce turnover
- Cost of living pressures on services

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care		High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care

Infrastructure and enablers / Havering place based partnership / Luke Burton, Borough Director, luke.burton1@nhs.net

The benefits that Havering residents will experience by April 2024 and April 2026:

April 2024:

- Have access to **Mental Health Practitioners** through their local Primary Care Network Team, providing low level mental health support, to support people to access early intervention and support, prior to requiring more intensive support for which they may not meet threshold
- Residents will have input into the all age **Learning Disability Strategy** for Havering which will be published by April 2024, with a clear action plan setting out how Learning Disability services in Havering will be improved over the next five years
- Benefit from a joined up approach to **Quality**, with Quality Improvement embedded in every part of the delivery of their care. A single Havering forum will have oversight of quality from a borough perspective, with a particular focus on the handovers between care to ensure that these are seamless and smooth, and to review and learn from times when this is not the case
- A comprehensive and joined up **vaccination and immunisation programme** that reaches out to local people to deliver vaccs and imms in the places that work best for them, and will deliver multiple inoculations at the same time, where it is possible to do so, ensuring that, particularly the most vulnerable, are vaccinated.
- The foundation of a **Population Health Management system** will enable all workstreams to embed proactive and anticipatory care, supporting earlier interventions to prevent deterioration and supporting local people to remain well at home for longer.
- The foundation for a more integrated approach to workforce recruitment and development will be in place, learning from the significant developments in the Care Sector to develop 'Passports' and online learning platforms, alongside innovative
- Use of **technology** to improve productivity of front line staff, particularly Health Care Assistants, will create capacity and identify deterioration early, improving outcomes for local people
- Development and roll out of a **single directory** for health, care and VCS services that everyone has access to will support right care, first time

April 2026:

- **Mental Health practitioners** and other staff within the Primary Care Networks will work as part of a virtual integrated multidisciplinary team, responding to the needs of local people, and providing them with comprehensive mental health support as soon as they need it
- The **Havering All Age Learning Disability Strategy Action plan**, embedded within the strategy, codeveloped with local people, community and voluntary sector leads and health and care staff will progress at pace, tangibly improving outcomes for those with Learning Disabilities in Havering
- A comprehensive and fully integrated approach to **Quality** will ensure that failures in care, and in particular in the transitions between care, are identified and learned from in a timely manner to prevent further occurrences. All staff, across health, care and the VCS will be aware of how to identify and escalate potential issues before they become a failure in care.
- A comprehensive and fully integrated vaccs and imms programme, that delivers interventions to local people in the places that they prefer, in a way and with messages that are meaningful to them, will ensure that a greater proportion of the population is protected.
- A comprehensive and data driven **population health insights platform** which brings together information from health and care, across primary and secondary care, will identify key areas where service improvement is required, and will also enable greater proactive care to take place. This will ensure that local people have services tailored to their needs, with enough capacity to be responsive, and will enable earlier intervention to support people to remain well, before their conditions exacerbate.
- Greater use of technology will significantly increase the productivity of front line staff, supporting local people to remain well for longer and preventing deterioration particularly in the community, catching it before it requires hospitalisation
- The **single directory**(Joy) will be fully developed and rolled out and recognised and used throughout the borough, supporting right care, first time.

How this transformation programme reduces inequalities between north east London's residents and communities:

- By ensuring that all groups of people, including those for whom English isn't a first language, or who may have previously been mistrustful of vaccinations or not able to access to the vaccination sites, are able to speak to a local vaccs and imms team, within their community, who is able to answer their questions and support them to have the vaccinations that will protect them from potentially harmful diseases.
- By ensuring that everyone, including staff, have access to an easy to use director of services, showing all of the support that is available to them in their local area. This is translatable into many languages, and with staff from health, care and the community and voluntary sector, and unpaid carers/family members able to access this information to support residents who are less able to use technology, all residents should benefit from this.
- By ensuring that those with a Learning Disability have a clear strategy and action improvement plan to address inequalities for this group of people, improving life expectancy and access to services, and supporting codesign of services that are meaningful to them to achieve the outcomes that they want

Key programme features and milestones:

Mental Health practitioners within PCNs:

- Work with NELFT to develop a comprehensive training and development programme and appropriate supervision for those working in these roles
- Support PCNs in Havering to recruit to the Mental Health Practitioner roles
- All Mental Health Practitioner roles in Havering to be recruited to, and working as a virtual team across all PCNs

Learning Disability Strategy:

- April 2023 Specification to be developed for the strategy development
- June 2023 Procurement process to identify support to develop the strategy from the Community and Voluntary Sector, working closely with local people
- From July/August 2023 identified CVS lead to take forward development of the strategy with local people, based on their needs and aspirations, alongside development of a clear improvement action plan

Further transformation to be planned in this area:

- Over the next two years
  - Development and promotion of the Joy app to build a comprehensive service directory in Havering that everyone has access to
  - Development of an all age LD strategy that is owned and taken forward by all partners in Havering
- Over years three to five
  - Implement and deliver the all age LD strategy action plan in Havering

Programme funding:

- Mental Health Practitioners to be recruited using ARRS funding with PCNs
- Places are awaiting confirmation from NHS NEL on the budgets for place, to take forward these projects in a sustainable way

Leadership and governance arrangements:

- Havering LD and Autism Working Group
- Havering Integrated Care Coordination and Social Prescribing Network
- Havering Quality Improvement Working Group

All of these groups feed into the Havering Place based Partnership Board

Key delivery risks currently being mitigated:

- Resource to deliver the initiatives is a significant risk until the ICB consultation is worked through and there is an established team at place. We are working to mitigate this, for example, there is currently no LD strategy for Havering, so we are going to work with the community and voluntary sector groups who support local people to develop the strategy, so that we have capacity to develop it, and so that they can truly own and shape it.
- The partnership is using funding from several sources to take forward our initiatives in 2023, but await confirmation of place budgets to take our programmes forward in a more sustainable, ongoing way
- Access to data, and data sharing continues to be a risk

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London

Building Community Resilience / Havering place based partnership / Luke Burton, Borough Director, luke.burton1@nhs.net

The benefits that Havering residents will experience by April 2024 and April 2026:

April 2024:

- Codesign of the all **age obesity strategy in Havering** and subsequent action plan, to create a healthier Havering (Havering currently has one of the most overweight populations in London), supporting people to remain well and healthier for London and signalling greater investment and focus on being active and promotion of healthier eating options across the borough to support local people to make healthier choices that will improve their wellbeing and ultimately, healthy life expectancy
- Codesign with local people and partners of an all **age Havering Carers strategy** and subsequent action plan, that will ensure that gaps in service provision and addressed, and unpaid carers are identified and supported, to prevent the deterioration of their wellbeing. This will be supported by **training for unpaid carers** via health inequalities monies in 2023 to equip them with the skills they need to fulfil their caring role
- Codesign with the VCSE and partners of the **Community Chest programme** via which £100,000 has been invested in 15 community and voluntary sector groups running initiatives to improve the wellbeing of local people, address the Core 20+5 Health Inequalities, and support social prescribing / Local Area Coordination.
- Core Connector programme – As the pilot site for NEL this truly place based initiative is intensely focused on addressing health inequalities in our most deprived area, Harold Hill (Gooshays ward). Volunteer Core Connectors have been recruited from the local community; the Core Connectors go out into the community and support local people, particularly those experiencing inequalities and barriers to accessing care and support, to get the information and support that they need. The programme is Havering is being identified as a gold standard for this nationally.
- A comprehensive approach to **supporting people to stay well at home**, with a wide range of initiatives to ensure that local people are supported in the community, without the need to be transferred to hospital, improving their journey and outcomes, and overall wellbeing. Targeted work to join up care being provided to **housebound** patients will allow patients and their families to be **better informed** about their care.
- Care Providers Voice are leading innovation in the Care sector aimed at improving the delivery of Domiciliary Care and Care in homes thus improving experience of care, and outcomes for local people and improving recruitment and retention of staff, through: Significant Seven training for Dom Care Staff and using technology to improve training and development and workforce placements, and enabling more flexible workforce models.

April 2026:

- Ongoing delivery of the Havering **All Age Obesity strategy** action plan will see significant improvements to the activity, and excess weight of local people. Local people will be able to have conversations with health, care and VCSE staff about the support available to them to help them become more active and to make healthier food choices, and will also be able to easily access this information themselves online. Their overall wellbeing, both physical and mental, will be improved, and the healthy life expectancy in Havering will improve.
- Ongoing delivery of the **Havering all age Carers Strategy** will see improvements in the number of people identifying as Carers and formally registering with the Havering Carers Hub. Through this, an increased number of people will access a Carers assessment, and receive the support and guidance that they need. This will improve the health and wellbeing of both informal Carers, and the people that they care for. There will be improvements to respite services, and care coordination to further support this.
- Subject to confirmation of ongoing funding, the **Core Connector programme** in Harold Hill will be expanded to other areas of the borough such as Rainham, where the population there will benefit
- Our **Care** workforce recruitment and retention will be significantly improved, with a comprehensive training and development programme for all paid carers in Havering, with career development pathways embedded such as Training Nurse Associates and AHP assistants, and comprehensive work with local schools to improve the pipeline of local people entering careers in care.
- Through our **supporting people to remain well at home** programme, we will see improvements in the number of people supported to remain well at home, improving outcomes for them and reducing pressure on the acute hospital so that if local people need emergency care, they are able to be seen more quickly.

How this transformation programme reduces inequalities between north east London's residents and communities:

- Core Connectors in Harold Hill are based directly in the community and providing outreach to groups who often feel marginalised by traditional methods of health and care delivery, including; being based in the heart of the community by the community pantry, speaking with local people who are relying on subsidised groceries, reaching out into the traveller community to support them to access health and care, directly reaching out to those who are 'housebound' in Harold Hill to ensure that they are getting the support and care that they need, and engaging directly with people struggling with their housing, and those who may be refuges, to support not just access to health, care and benefits, but working with them to address their wellbeing, and look at their future career prospects etc.
- The supporting people to stay well at home programme will ensure that local people, particularly those who may be housebound and have complex needs but may not necessarily be able to advocate for themselves, receive comprehensive support and care, and are able to stay at home/ in their preferred place of residence for as long as possible, without the need for unnecessary hospital admissions.
- Supporting paid carers to access comprehensive training, development and support, and have career development options, to improve their wellbeing, and recruitment and retention in this key work group

Key programme features and milestones:

- Develop the Havering All Age Carers Strategy: engagement and codesign with local people underway, 1-1 discussions and focus groups undertaken to understand what is most important to local people.
- Increase identification of carers in Havering. There are currently 1,700 people registered with the Carers hub, through which they can access an assessment and further support. We know that there are many more Carers than this in Havering (data request with primary care currently for the number of carers registered within their PCNs). Training that we are running in 2023 will be shared widely across the borough for unpaid Carers and encourage people to identify as a Carer, and sign up for further support.
- Obesity strategy workshops held, and significant engagement with partners and local people undertaken to develop the strategy, and subsequent action plan. Further development of the action plan and strategy, which will be launched later in 2023.
- Core Connector programme to continue to develop and embed, with feedback to the national team and sharing of the learning. Currently capturing information on the impact of the interventions.

Further transformation to be planned in this area:

- Over the next two years
  - Launch of the Havering all age Carers strategy
  - Launch of the Havering all age obesity strategy
  - Continuation of the Community Chest programme
- Over years three to five
  - Delivery of the Havering Carers strategy action plan
  - Delivery of the Havering Obesity strategy action plan
  - Robust programme of community chest funding and monitoring of impact

Programme funding: £747,000 Health Inequalities programme funding (2022/23)

- £100,000 will deliver the Community Chest programme
- £100,000 will support unpaid and informal carers
- £25,000 to deliver some of the initial initiatives in the Obesity strategy action plan
- £60,000 to deliver improvements to housebound patient care

Leadership and governance arrangements:

- Havering Core Connector Project Group
- Havering Carers Strategy Development working group
- Havering Obesity Strategy working group
- Havering Community Chest Programme Working Group

Key delivery risks currently being mitigated:

- Havering is underfunded in relation to public health funding and other funding such as the Grant to the Local Authority, which has not changed in 10 years and of which now 70% is spent on social care support; this is due to historical funding formulas which do not take into account the significantly changing demographics in Havering. This is a risk that could lead to the exacerbation of inequalities; partners continue to lobby for the changes in population to be taken into account when consideration is given to health inequalities funding, as an example.
- Resource to deliver the initiatives is a significant risk until the ICB consultation is worked through and there is an established team at place. Partners are working together to try to mitigate this.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

St George's Health and Wellbeing Hub / Havering place based partnership / Luke Burton, Borough Director, luke.burton1@nhs.net

The benefits that Barking & Dagenham, Havering and Redbridge residents will experience by April 2025

- Receive care for renal, outpatient, long term conditions, ulcers, speech and language therapy, access to diagnostics such as MRI, CT, X Ray and Ultrasound, dermatology, minor ops, early cancer detection and GP services at the new St Georges Health Hub Facility
- Access a larger emergency department at Queens hospital
- Be provided with community spaces and access to joint teams of health and social care professionals all in one place

How this transformation programme reduces inequalities between north east London's residents and communities:

- Supporting reduction of waiting lists for those in Outer NEL where waiting lists and care pressures are higher
- Allow more targeted holistic interventions of socially excluded groups such as older people and families in poverty
- Follow the equalities of funding agenda across NEL by providing needed local infrastructure
- Increase the support of children and families facing deprivation
- To use the integrated model to support vulnerable groups with holistic support such as benefits maximisation, housing support and the reduction in obesity

Key programme features and milestones:

- Start construction of St Georges Hospital – Enabling works August 2022, main construction to begin **Feb 2023**
- Complete construction – **May 2024**
- Formal opening of new St Georges Hospital Site – **Spring 2024**

Further transformation to be planned in this area:

- Over the next two years the St Georges Hub will be built and a number of the services above will be moved into or begin operating from the site
- Ongoing work with the local community to ensure the space is best utilised

Leadership and governance arrangements:

- St Georges Project Board reports into NELFT, BHRUT, Barts and NEL ICB statutory Boards

Programme funding:
£38.7m: Comprised of £17m from Wave 4 (b) funding, £968k from the sale of Elm Park, ICS allocation of £20.7M that is within operational capital envelopes

Key delivery risks currently being mitigated:

- Delays to construction planned start date
- Increased construction costs
- Workforce

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Living well / Havering place based partnership / Luke Burton, Borough Director, luke.burton1@nhs.net

The benefits that Havering residents will experience by April 2024

- April 2024:
  - Patients will be empowered to detect and manage cardio vascular disease risk factors such as hypertension, high BMI, high cholesterol, pre-diabetes and diabetes through the provision of POCT (**point of care testing equipment**) which will be deployed at three PCN (Primary Care Network) Hubs, all 10 Havering libraries and all phlebotomy sites, making access to such equipment easier
  - The provision of POCT equipment at the three PCN hubs will also reduce the need for patients to go for testing at other sites in the borough, as GP practices will have this testing ability on site, saving patients unnecessary journeys and time
  - Havering has been without a **stop smoking service** since 2015, about 20% of residents smoke – they will now have access to a new stop smoking service which will be available in local pharmacies throughout the most deprived parts of our borough, particularly in Rainham, Harold Hill and Romford.
  - Residents who have a **learning disability and/or mental health** will also be able to access a new **stop smoking service** tailored to their needs, this has been co-designed around their needs as traditional stop smoking pathways and environments do not work as well for those with mental health and/or learning disabilities
  - Residents who are rough sleeping, in temporary accommodation, asylum seekers and refugees will all have access to a new **mental health outreach service**

How this transformation programme reduces inequalities between north east London's residents and communities:

- Smokers have comparatively poorer health than non smokers, smoking is move prevalent in the more deprived wards – by locating the stop smoking services in the parts of Havering where both smoking and deprivation rates are high, this will help target the intervention at those who need it most so that they can stop smoking and move towards having equitable health outcomes in line with those from the least deprived parts of Havering
- Those who are rough sleeping, housed in temporary accommodation, seeking asylum or refugees have comparatively poor physical and mental health, subsequently they tend to be high users of health care services. Through offering bespoke services to their needs, their engagement with healthcare services will improve in order to prevent them presenting at crisis point.
- By locating point of care testing equipment around accessible community hubs such as libraries and PCN hubs in the most deprived parts of our borough, this improves the accessibility to prevention and detection services for those who would otherwise struggle to access this

Key programme features and milestones:

- Recruitment of mental health outreach nurses by July 2023
- Launch of mental health outreach service by August 2023
- Deployment of point of care testing equipment and launch of service by April 2023
- Launch of stop smoking service by March 2023
- Launch of stop smoking service for those with a learning disability and/or mental health by April 2023

Further transformation to be planned in this area:

Over the next two years

- Expansion of stop smoking services to other parts of the borough, increase in stop smoking offer
- Commissioning of additional outreach services for those rough sleeping, in temporary accommodation, asylum seekers and refugees
- Increasing the number and type of point of care testing equipment available

Programme funding:

- £747,500 from Health Inequalities fund
  - £40k – Point of care testing/self service health check offer
  - £150k – mental health outreach for homeless
  - £52.5k – stop smoking services

Leadership and governance arrangements:

- Havering Health Inequalities Leadership Group which accounts into the Havering Place Based Partnership Board

Key delivery risks currently being mitigated:

- Finance - Potentially reduced levels of Health Inequalities funding being received
- Workforce – both London Borough of Havering and ICB staff being significantly cut, capacity of workforce to deliver and potential for key staff delivering change being lost

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Ageing Well / Havering place based partnership / Luke Burton, Borough Director, luke.burton1@nhs.net

The benefits that Havering residents will experience by April 2024

Ageing well monies used to support people with the impact of the increases in cost of living, Havering partners have come together to **fund warm hub**s, for local people to access, in some of the most deprived areas of our boroughs. These ensure that people have a warm place to sit throughout the day during the colder months, with refreshments, activities focussed on improving wellbeing, and information and advice including; energy, benefits, housing, and health messages – NB there are no restrictions around age in terms of access to this support.

Cost of living payments innovatively directed to those with lifesaving technology at home, to support with the cost of running this to ensure that local people can continue to remain supported at home – NB there are no restrictions around age in terms of access to this support. The ageing well portfolio of projects includes the following (provision of warm hub spaces, provision of essential life critical apparatus to support living at home, recruitment of Age UK Navigators to guide people through the complex health and social care system , additional strength and balance classes to reduce the increasing number of hospital related falls activity, increasing the provision of reablement care hours and support available, provision of in reach reablement to hospital wards, grants to develop primary care network anticipatory care offers, increase the number of local area coordinators, British Red Cross will take residents from care homes to medical appointments reducing the pressure on care home staff, the issue of blue bands to care home patients with dementia to help hospital staff identify dementia patients and tailor care to their needs), these will all help:

- Provide vulnerable older people with safe, warm environments, improve connections for isolated individuals with the local community, provides funding towards energy bills to maintain 24 hr essential health apparatus for those struggling to afford the costs
- Promote better mobility and reduce falls
- Re-enable older peoples mobility and self-confidence post an urgent care episode or post discharge
- Keep older people well and safe at home
- Enable older people in care homes to attend medical appointments

How this transformation programme reduces inequalities between north east London's residents and communities:

- Reduces risk for frail older people living in the community
- Reduces isolation for older people
- Promotes independence for older people, enabling them to live in their community for longer
- By Identifying and targeting those with lifesaving equipment at home, and asking them to complete a short form to access an additional one off payment to help them to fund this (criteria dependant to ensure that it supports those in greatest need), we have been able to ensure that local people, particularly the most vulnerable, are able to continue to run lifesaving equipment at home. This payment was on top of other schemes aimed at supporting local people with the cost of living impact

Key programme features and milestones:

- Increase falls classed by 12 per month before Jun-23
- Open warm hubs – Jun-22
- Energy Payments for essential life critical apparatus go live – Feb-23
- Continue reablement hours levels through til Jun-24
- Launch reablement pilot – Mar-23
- Pilot proactive care MDT – Mar-23
- Blue Bands to be used in care homes from Mar-23
- Care Medical escorts – go live February 2023

Further transformation to be planned in this area:

- Over the next two years
  - Roll out of Proactive Care across all PCNs fully by early 2024/25
  - Sustainable reablement care hours to be system funded from Q2 2023/24

Programme funding:

- £1.5M Ageing Well - Non-Recurrent through the BCF sec 75 agreement

Leadership and governance arrangements:

- Reporting to the Place Based Partnership Board
- Havering Place Ageing Well Working Group

Key delivery risks currently being mitigated:

- Workforce Recruitment
- Project Management and PMO capacity

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care	✓	High-trust environment	
Long-term conditions	✓	Employment and workforce		Prevention	✓	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Newham Frailty Model / Newham Place-Based Partnership / [SRO and email address]

The benefits that Newham's residents will experience by April 2024:

- April 2024:
  - Holistic support offered to residents and carers to improve quality of life outcomes
  - Residents with frailty will be supported by the frailty MDT to achieve a set of coproduced and personalised goals
- April 2024:
  - Factors that contribute to resident A&E attendances and unplanned hospital admissions will be minimised
  - Factors that contribute to resident GP encounters will be minimised

How this transformation programme reduces inequalities between north east London's residents and communities:

- By ensuring that the cohort of residents identified and supported by the frailty MDT reflect our current demographic profile
- By bringing clinical and care professionals together to review resident cases with a holistic view e.g. the wider determinants of health

Key programme features and milestones:

- Anticipatory care / proactive care
- Geriatric assessment pathways
- Multi-disciplinary teams for frailty
  - Stratford PCN pilot project mobilised from May 2022 to February 2023
  - Midway review in October 2022
  - Evaluation of the pilot is expected to be delivered by March 2023 – the pilot evaluation will feed into the development of our local anticipatory care model
  - Rollout frailty MDT to other PCNs across Newham

Further transformation to be planned in this area:

- Over the next two years
  - Virtual wards for frailty
  - Falls pathway
  - Develop design principles for integrated frailty hub

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Frailty Model Working Group chaired by Dr Rehana Aslam (Clinical Lead for Frailty), which reports up to the Newham Ageing Well Joint Planning Group

Key delivery risks currently being mitigated:

- Funding beyond the frailty MDT pilot not secured
- No national guidance around proactive care
- Recent operating guidance indicates that DES funding for proactive care will not be included

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Newham Neighbourhood Model / Newham Place-Based Partnership / [SRO and email address]

The benefits that Newham's residents will experience by April 2024:

- April 2024:
  - Tailored Interventions and services according to prevalence across geographic area that are closer and more accessible to residents
  - Support the improvement in outcomes around LTCs and NCDs
- April 2024:
  - Residents are effectively supported around the wider determinants of their health and wellbeing in a holistic, strength-based and inclusive way

How this transformation programme reduces inequalities between north east London's residents and communities:

- By utilising population health data to analyse needs, trends and demographics, and develop new services based on local insights and intelligence
- By talking to residents to find out what type of services they would like in their area
- By tailoring services and information (translate flyers, bilingual sessions, online presence, whilst maintaining regular sessions in the community)
- By ensuring services and delivery is Accessible, Relevant and Trusted, to reduce health inequalities and support good health

Key programme features and milestones:

- To implement the requirements of Fuller Review.
- Neighbourhood pilot project taking place in the south-east of the borough ('Quadrant 4')
  - Join up with the LBN Healthier Lives Programme to test some of the neighbourhood ways of working across the categories of the programme:
    - Treating tobacco dependence service
    - Specialist all-age weight management and movement service
    - Community projects for health and wellbeing
    - Addressing resource inequality

Further transformation to be planned in this area:

- Over the next two years
  - Learn from test and learn approach and agree plan for further developing neighbourhood model.
  - Review LTC pathways for impact
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Neighbourhood Working Group chaired by Dr Scarlett Gard (Clinical Director for Docklands PCN), which reports up to the Newham Clinical and Care Professional Senate

Key delivery risks currently being mitigated:

- Aligning governance and current footprints for delivery of care / services across the various providers and organisations
- Identifying funding for priority neighbourhood programmes

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Newham Population Growth / Newham Place-Based Partnership / [SRO and email address]

The benefits that Newham's residents will experience by April 2024 and April 2026:

- April 2024:
  - An infrastructure plan for Newham built from the service delivery strategy, to enable the required population health service initiatives to improve health outcomes in the borough over a 20-year + time horizon
- April 2026:
  - High levels and quality of service delivered from sufficiently-sized and equipped premises as the population grows
  - X

How this transformation programme reduces inequalities between north east London's residents and communities:

- Ensure Newham system is best placed to deal with the challenge of future population growth
- By focussing on buildings that provide for the needs of the local population, offer appropriate capacity, access and a positive experience
- By focusing on prevention and early intervention as a Newham place system to support patients and residents access help as early as possible including from primary, community and VCSF sector

Key programme features and milestones:

- Secure project management support and design population growth priorities and programmes
- Establish the governance, including establishment of the Local Infrastructure Forum
- Continue to support the development of Well Newham including all age offer and social prescribing support that is readily available and acceptable

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Local Infrastructure Forum, which reports up to the Newham Health and Care Partnership Board
- The programme is also sponsored by the Newham Health and Wellbeing Board

Key delivery risks currently being mitigated:

- Level of change and transition within the system
- Programme management capacity and resources to develop SOC
- Alignment of timescales between various site programmes
- Availability of revenue and capacity to take forward recommendations within the SOC
- Customs House s106 funds of £7.5m allocated specifically to a new scheme in customs house redevelopment which currently does not have a confirmed service strategy for this location – both NHS and LA.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Learning Disabilities and Autism / Newham Place-Based Partnership / Richard Fradgley, Executive Director of Integration, ELFT rfradgley@nhs.net

The benefits that Newham's residents will experience by April 2024 and April 2026:

- April 2024:
  - Residents get the right help at the right time from the right people
  - Residents have a team around them who know their needs and their plans and work together to help them achieve them
- April 2024:
  - Carers are supported to have a life alongside and outside of their caring role
  - X
  - X

How this transformation programme reduces inequalities between north east London's residents and communities:

- By identifying and agreeing priorities that are locally focussed based on data and evidence
- By focussing on universal to specialist level of needs using population health management approaches
- By having a strengthened focus on equity, equality and challenging racism and all forms of discrimination
- By working with and across all system partners, with a strengthened focus on residents voice from the start of any project

Key programme features and milestones:

- April 2023 – Agree a small number of initial priorities for partners to work together to deliver better outcomes for residents, staff and the system
- Autism Diagnostic Service and Autism service mapping
- Independence to an Ordinary Life

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Learning Disabilities and Autism Joint Planning Group chaired by the Clinical Lead and LBN AD of Commissioning, which reports up to the Newham Health and Care Partnership Board and NEL MHLDA Committee

Key delivery risks currently being mitigated:

- X
- X

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Ageing Well / Newham Place-Based Partnership / Jason Strelitz, Director of Adult Social Care and Public Health, LBN jason.strelitz@newham.gov.uk

The benefits that Newham's residents will experience by April 2024 and April 2026:

- April 2024:
  - Residents are able to plan for their future care and after their death – ensuring their wishes are known and respected.
  - Residents receive safe, high-quality Health and Social Care as needed
  - Increase in the number of 'End of Life Care' residents who die in their preferred place of care and death.
  - Improved early identification of long-term conditions or disability, including frailty and dementia.

How this transformation programme reduces inequalities between north east London's residents and communities:

- By identifying and agreeing priorities that are locally focussed based on data and evidence
- By focussing on universal to specialist level of needs using population health management approaches
- By having a strengthened focus on equity, equality and challenging racism and all forms of discrimination
- By working with and across all system partners, with a strengthened focus on residents voice from the start of any project

Key programme features and milestones:

- April 2023 – Agree a small number of initial priorities for partners to work together to deliver better outcomes for residents, staff and the system
- Further develop our palliative and end of life care pathways to enable support where and when people wish
- Develop our falls services and support
- Roll out our frailty pilot with a focus on MDTs and delivery of virtual ward services
- Develop and deliver plans for intermediate and anticipatory Care
- Timely and accurate diagnosis of dementia, and improved pre and post diagnostic care

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Ageing Well Joint Planning Group chaired by the SRO, which reports up to the Newham Health and Care Partnership Board and Newham Ageing Well Strategy Delivery Board

Key delivery risks currently being mitigated:

- X
- X

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Primary Care / Newham Place-Based Partnership / Karen Livingstone, CEO, NHC karen.livingstone4@nhs.net and William Cunningham-Davis, Director of Primary Care, NEL william.cunningham-davis@nhs.net

The benefits that Newham's residents will experience by April 2024 and April 2026:

- April 2024:
  - X
  - X
  - X
- April 2026:
  - X
  - X
  - X

How this transformation programme reduces inequalities between north east London's residents and communities:

- By identifying and agreeing priorities that are locally focussed based on data and evidence
- By focussing on universal to specialist level of needs using population health management approaches
- By having a strengthened focus on equity, equality and challenging racism and all forms of discrimination
- By working with and across all system partners, with a strengthened focus on residents voice from the start of any project

Key programme features and milestones:

- April 2023 – Agree a small number of initial priorities for partners to work together to deliver better outcomes for residents, staff and the system
- Develop our Primary Care Strategy in line with the Fuller Report recommendations, ensuring swift access and continuity of care for different groups and needs
- Reduce variation in practice and outcomes especially in relation to Long Term Conditions

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Primary Care Planning Group chaired by the SROs, which reports up to the Newham Health and Care Partnership Board

Key delivery risks currently being mitigated:

- X
- X

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Health Inequalities / Redbridge Place / SRO: Tracy Rubery, Borough Director, NHS NEL (tracy.rubery@nhs.net)

The benefits that Redbridge residents will experience by April 2024 and 2029:
By 2024

Health Inequalities

- Improved trusted relationships with communities through **RCVS Health Buddies** – through outreach work and awareness sessions with residents
- **Health Engagement Bus** – By 2024 residents will have improved access and awareness to services such as Health Checks, Childhood immunisations, Sexual Health and Substance misuse interventions
- **Culturally specific engagement officers –** By 2024 the Roma community will feel more inclusive and have equitable access to mainstream health social care services.
- **Wearable Tech** – More residents will have the opportunity to access and use wearable tech alongside recognised interventions such as nutritional advice and physical activity programmes to tackle areas such as prediabetics, hypertension and mental health issues.
- **Childhood immunisation pilot –** Improved patient access by reviewing data and putting interventions in place, reviewing access, times and locations so routine imms can be done that suits parents.
- **Social Prescribing community chest** – improved awareness of health and social care services using local organisation/charities/faith leaders in settings that targets certain communities.
- responding to community intelligence, and promoting sustainable impact for communities and addressing key priority areas related to reducing health inequalities in underrepresented communities
- **Community Cash Fund and Insights** – By 2024 under represented communites,will have more represented acces to a range of local health services for example hospices, post Covid and mental health services.
- **Door to door engagement** – By 2024 under represented communities will feel more engaged and have equitable access to mainstream health and social care services, through raised awareness and targeted engagement.

How this transformation programme reduces inequalities between north east London's residents and communities:
Targeting specific populations within Redbridge to inform and address inequalities and access to services by underrepresented groups
Targeting the Roma communities to improve access and increase awareness on health
Targeting practices/PCNs with granular data profiles to identify proportionally higher numbers of people from specific ethnicities on their case lists to identify specific ethnicities who have markers for pre-diabetes
Targeted messaging to better support these communities and individuals in relation to our specific focused conditions and access to services

Key programme features and milestones:
Childhood IMMs Pilot - Project started in July 2022 with project group being established and project plan agreed. MOUs have been drafted and signed by all 42 practices.
Engagement – onboarding of staff to structure and finalising door process and expand network opportunities.
Healthwatch – number of events planned to engage with underrepresented communities in March. MH First Aid training events planned for March
Health Engagement Bus – planning for launch event and more services onboarding. Exploring venues with community networks

Further transformation to be planned in this area:

Depending on recurrent funding the plan is to build on current initiatives.

Programme funding:

£791,500 – NHS Health Inequalities

Leadership and governance arrangements:
SRO: Hilary Ross
Finance Lead: Julia Summers
Governance: NEL Health Inequalities Steering Group
Placed Based Partnership Board

Key delivery risks currently being mitigated:
- Risk of recurrent Funding going forward to further develop programmes
- Workforce recruitment to support the programme.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Accelerator Priorities / Redbridge Place based Partnership / Tracy Rubery, Borough Director (tracy.rubery@nhs.net)

The benefits that Redbridge residents will experience by April 2024 and 2029:

By 2024

Accelerator Programme:

- **Childhood Vaccination** – By 2024 residents will have a more co-ordinated communication approach from system partners with one message. .
- **Housing and Overcrowding**, - By 2024 residents will have more community space available for respite from overcrowding.
- Vulnerable residents will be discharged to a sfae and stable environment to support their recovery from hospital.
- **Mental Health** – By 2024 residents will have equitable access to low level mental health services and feeling reduced stigma.
- By 2024 a wider range of staff across the system will have had access to vital mental health support training.
- **MDT working** – By 2024 parents of children and family and carers of dementia patients will experience a more holistic care approach through the development of multi-disciplinary teams across system partners.

How this transformation programme reduces inequalities between north east London's residents and communities:

- Targeted initiatives that aim to engage underrepresented communities.
- Tackling stigma in communities to ensure equitable access for the whole population
- Through MDTs providing a holistic approach to care residents experiencing a one stop shop
- Supporting the most vulnerable with housing and overcrowding by providing a raft of different support

Key programme features and milestones:

- Develop integrated governance arrangements across partners.
- Set up a task and finish group with system partners to drive forward the MH and Paediatric agendas.
- Analyse local vaccination data across PCNs to understand where we need to focus vaccination programmes.
- Plan and set up a GP paediatric Hub that includes Acute, primary care, health visiting and Early years services.
- Develop proposals that will address the wider aspects of Housing and Overcrowding to support vulnerable communities.
- Develop an overcrowding information leaflet to share with residents at engagement events and via the Redbridge website.

Further transformation to be planned in this area:

- Develop strategy for every contact counts for paeds vaccinations by 2024.
- Supporting the delivery of the Suicide prevention strategy by 2024.
- Develop and deliver a MDT model for Dementia Care by 2025.

Programme funding:
No funding currently Identified

Leadership and governance arrangements:

Each Programme area has a designated SRO
Each programme has a Project Lead with support

Governance: Redbridge Placed Based Board

Key delivery risks currently being mitigated:

- Securing funding to deliver the required initiatives.
- Having sufficient workforce to lead on the range of schmes to deliver the overall objectives.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Development of Ilford Exchange Health and Care Centre / Redbridge Place based Partnership / Tracy Rubery, Borough Director (tracy.rubery@nhs.net)

The benefits that Redbridge residents will experience by April 2024 and 2029:

By 2024

- **Ilford Exchange Health and Care Centre**
- Expand capacity of 2 local GP Practices to accommodate the growing population
- Deliver a new Blood Test and Podiatry Service for local residents
- Deliver a Talking Therapies service in a central location
- Relocate Health And Social Service (HASS) services
- Relocate Health Visiting & School Nursing Services into the centre
- Deliver a Long Term Conditions (LTC) hub to include key conditions, e.g. diabetes, respiratory.

By 2029

How this transformation programme reduces inequalities between north east London's residents and communities:

- Ensure equitable access for all communities with care closer to home in a central location
- A flexible, modern space that can adapt to the changing needs of the population
- More space to allow existing health and care services within a two-mile radius to expand to support more patients
- More space to provide new health services not previously available in Ilford town centre
- A "one-stop-shop" where people can access more than one service in a single visit.
- NHS, social care and the voluntary sector working together to make patient care more joined up
- Ensure more of Ilford's diverse communities are able to access the health and care support services that they need

Key programme features and milestones:

- Set up governance arrangements to oversee the development and delivery of the new health and care centre.
- Review feedback from the extensive engagement exercise with local residents to ensure their views are incorporated into the development.
- Agree the range of services to be delivered from the new health and care centre.
- By April 2024 mobilise the services and have a grand opening.

Further transformation to be planned in this area:

- Evaluate service delivery of new centre
- Look at further opportunities- to introduce new services.

Programme funding:

TBC

Leadership and governance arrangements:

SROs: Adrian Loads, Tracy Rubery
Governance: NEL ICB, Redbridge Place, NELFT Executive, PCN Boards

Key delivery risks currently being mitigated:

- Risk of securing the funding from the system.
- Risk of recruiting the necessary workforce in time for opening.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Living Well / Tower Hamlets / Warwick Tomsett - Warwick.Tomsett@towerhamlets.gov.uk

The benefits that Tower Hamlets residents will experience by April 2024

- Strengthened Locality & PCN structures which are better able to locally identify and address health inequalities
- Improved pathways between communities and long term conditions services to better prevent and manage long term conditions
- More engagement with local communities to involve them in how services to improve their health and wellbeing are developed
- Improved access to health and care services for residents with disabilities

How this transformation programme reduces inequalities between north east London's residents and communities:

- By improving access to health and care services for residents with disabilities
- By preventing **long term conditions** and improving outcomes, including focusing on groups where LTCs may be more prevalent than others

Key programme features and milestones:

- Strengthening locality and PCN structures will involve working with our 4 locality committees to understand their population and deliver work accordingly and to work with PCNs to improve health inequalities through co-production and greater links with pharmacies
- LTCs prevention and management will feature improved pathways for links to health services after detection, improved prevention pathways for those at LTC risk
- Improving access to health and care services for residents with disabilities will involve building on the current pilot in 2 GP surgeries by extending this to other key services across all of our partners

Further transformation to be planned in this area:

- Over the next two years
  - Detailed project output with focus on PCN and locality approach
  - Further scoping of long term conditions priorities
- Over years three to five
  - Transformation plans to be confirmed i.e. phasing, scope and milestones

Programme funding:

- Public Health Grants
- Health Inequalities Funding
- Core based funding from LBTH and ICB
- Better Care Funds (BCF)

Leadership and governance arrangements:

- Principal strategic and operational oversight by Living Well Board
- Monthly delivery oversight by Local Delivery Board
- Quarterly assurance monitoring at THT Executive Board

Key delivery risks currently being mitigated:

- Limited data and data insights to determine activities, trends and population health management approach
- Gap on LTC lead in Tower hamlets

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care		High-trust environment	X
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Promoting Independence / Warwick Tomsett - Warwick.Tomsett@towerhamlets.gov.uk

The benefits that Tower Hamlets residents will experience by April 2024

- More effective and efficient discharge process from hospital to care at home and in the community
- A joined up approach to providing better, more holistic support for those who are homeless
- A joined up approach to providing better, more holistic support for residents with frailty
- Clear outcome-based framework and better experience for residents in the homecare
- More personalised and support care plan to be offered across residents to reduce long term resilience on care and improve overall wellbeing

How this transformation programme reduces inequalities between north east London's residents and communities:

- By improving outcomes for those who are **homeless**, who often experience some of the worst outcomes of any residents
- By accelerating the proactive approach and using population health management to identify residents who are **at risk of crisis** (anticipatory care)
- The use of cutting-edge approach to care coordination MDT and utilise health, care and other sectors to support **frailty** residents to be independent in the community

Key programme features and milestones:

- Joining up support services for homeless people will look to introduce a MDT care co-ordination pilot with key partners and service users to co-produce a new model of working **(June 2023 to May 2024)**
- Discharge to assess: TBD
- Joining up support for residents with frailty will seek to extend the current pilot in one PCN to further areas and embed the learning that has so far resulted **(May 2023 to April 2024)**
- Developing a new model of homecare will be an opportunity for us to use the re-procurement of the LBTH contract to identify and implement joint ways of working with health and community and voluntary partners to make the offer more holistic and improve outcomes for service users requiring care at home

Further transformation to be planned in this area:

- Over the next two years
  - Cohort Analysis (review) to determine further scope of work
  - Neighbourhood Approach in response to Fuller
  - Implementation of Frailty Care Coordination across all PCNs
- Over years three to five
  - Further review of programmes to determine additional work

Programme funding:

- Ageing Well, Better Care Fund, NEL Diabetes Partnership
- Personalisation - Personal Health Budgets
- Health Inequalities Funding
- Core based funding from LBTH and ICB

Leadership and governance arrangements:

- Principal strategic and operational oversight by Promoting Independence Board
- Monthly delivery oversight by Local Delivery Board
- Quarterly assurance monitoring at THT Executive Board

Key delivery risks currently being mitigated:

- Projects that do not have recurrent funding and risk of it being unable to continue to deliver
- Funding
- Recruitment – challenges to recruit roles specific to projects and transformations

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Centre of Excellence / Waltham Forest Place-Based Partnership / Sue Boon, Director of Delivery sue.boon@nelft.nhs.uk]

The benefits that Waltham Forest residents will experience by April 2024 and April 2026:

- April 2024:
  - Comprehensive, holistic support to manage complex care needs, including those residents with long term conditions
  - Access to virtual consultations with a range of specialists
  - Remote monitoring support, promoting resident impendence, through telehealth & telecare alignment
- April 2026:
  - Access to Wellbeing Lounge to support staying well for longer
  - Demonstrable reduction in A&E admissions, non-elective activity and bed days
  - Access to point of care testing

How this transformation programme reduces inequalities between north east London's residents and communities:

- By providing equity of access into the Centre of Excellence through clearly defined referral pathways
- By providing digital connectivity and capability to provide access to virtual services to all residents
- By considered estates planning through the programme executive to ensure the Centre of Excellence is delivered in a way which promotes equal access for all
- By providing proactive personalised care planning for those with complex health conditions

Key programme features and milestones:

- Digital Hub Virtual Remote Monitoring – launched for care homes Aug 2022. Nursing home focus in Q1 2023/24.
- Long Term Conditions (LTC) Hub/ Complexity Hub (holistic, specialist care for complex residents with LTCs) - to go live early 2023/24 as a virtual service offer
- LTC / Complexity Hub – face-to-face service offer by end of 2023/24
- Digital Hub Population Health Management – proactive data-based identification of residents who would benefit from early intervention – risk stratification tool to be developed and embedded during 2023/24
- Wellbeing Lounge (access to wellbeing services, VCSE, relaxation zone) – planning to commence in 2023/24
- Leadership, Innovation & Training Hub (staff training catalogue, portfolio careers, carers support, organisational development tools) – planning to commence in 2023/24

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- £9m - Section 256 funding (5 year programme)

	Year 1 (22/23)	Year 2 (23/24)	Year 3 (24/25)	Year 4 (25/26)	Year 5 (26/27)
£000s Spend	£335	£1,263	£2,101	£2,359	£2,935

Leadership and governance arrangements:

- Waltham Forest Health & Care Partnership Board
- Centre of Excellence Executive Group

Key delivery risks currently being mitigated:

- There is a risk that we will not deliver the business case for community health service transformation and not deliver the reductions in acute admissions required to support a new WX hospital
- There is a risk that appropriate estates will not be available when required which will impact on the type of service being delivered

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Care Closer To Home Programme/ Waltham Forest Place-based Partnership / Sue Boon- sue.boon@nelft.nhs.uk

The benefits that Waltham Forest residents will experience by April [2024] and April [2026]:

- April 2024:
  - Proactive identification and early intervention, delivering a neighbourhood health and care model that integrates and improves community care for all residents.
  - Improved anticipatory care planning that reduces hospital admissions
  - Reduced number of emergency hospital admissions and days spent in hospital
  - Improved health and social care outcomes through personalised rehabilitation, reablement and recovery support
- April 2026:
  - Early coordinated support, joint decision making and personalised care plans in place for those who are most likely to use hospital services.
  - Care Professionals working in partnership with each other and with the residents for aspects which require support, e.g. physical, mental health, social care needs, housing and financial issues.
  - Fewer people requiring emergency hospital admission
  - Improved access to services for patients with low level mental health issues

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing the immediate and medium-term impact of a non-elective hospital admission, helping people to access services closer to home
- By reducing the prevalence and impact of long term conditions on residents
- By providing proactive personalised care planning for those with complex health conditions
- By improving interventions and outcomes for those with long term conditions
- By integrating intermediate care services to improved accessibility and rehabilitative outcomes for residents

Key programme features and milestones:

- **Care home multi-agency response** - Enhanced MDT response to care home including MDT meetings
- **Multi-disciplinary working at PCN level** - Proactive case finding/MDT care planning for those at high/medium risk of a hospital admission.
- **Complex LTC management** - Co-design of clinical pathways for priority long term conditions e.g. respiratory, cardiovascular, diabetes in line with population health needs across the borough.
- **Primary care–led MH liaison** - Establish enhanced mental health pathways within primary care.
- **Enhanced domiciliary care support** - Recommissioning reablement to support greater number of home discharges, improve independence post discharge and to prevent hospital admission – likely to be delivered under the Home First Programme

Further transformation to be planned in this area:

- Over the next two years
  - All 15 Care / Nursing Homes undertaking monthly MDTs
  - Multidisciplinary working across all PCNs
  - Enhanced pathways to the top 3 disease prevalent conditions in WF
- Over years three to five
  - Multidisciplinary working across all stakeholders
  - Personalised care planning for patients at risk of hospital admission

Programme funding: - Approx. £2,106k over 5 years

Impact over 5 Years:

CC2H - Proactive Anticipatory Care	Non elective admission reduction	317	714	1,121	1,129	1,137
	Bed days saved	1,534	3,355	4,249	4,277	4,306
	Beds saved	4	10	12	13	13
	£'000 saved	£784	£1,732	£2,713	£2,731	£2,750

Leadership and governance arrangements:

- Waltham Forest Health & Care Partnership Board
- Care Closer to Home Executive
- Care Closer to Home Operational Leadership Group

Key delivery risks currently being mitigated:

- If a risk stratification criteria / tool is not in place, it will put more pressure on GP time to identify the appropriate patients to be discussed at the anticipatory MDT. Engaging with NEL Population Management Team to resolve this.
- Anticipatory MDTs rely on full participation of PCNs. If additional funding is not made available, this will impact the level of resources needed to support the programme. Working with Primary Care and the LMC to agree SNS with PCNs.
- There is risk of not accurately monitoring patient journey due to incomplete data from GP practices/PCN that cover Care/Nursing Homes.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Home First Programme/ Waltham Forest Place-based Partnership / Sue Boon- sue.boon@nelft.nhs.uk

The benefits that Waltham Forest residents will experience by April [2024] and April [2026]:

- April 2024:
  - Improved urgent care support at home that reduces the need to be conveyed to hospital
  - Reduced number of emergency hospital admissions and days spent in hospital
  - Earlier supported discharge home with appropriate support such as virtual ward/hospital at home
  - Reduction in delayed discharge through a discharge to assess model and transfer of care hub
  - Improved health and social care outcomes through personalised rehabilitation, reablement and recovery support
  - Improved resident and carers experience through meaningful engagement and a continuous learning culture
- April 2026:
  - Seamless health and care support through an integrated intermediate care service
  - Fewer people requiring emergency hospital admission and long-term adult social care support
  - Improved access to community therapy to support rehabilitation goals and outcomes
  - Greater number of services such as diagnostics delivered within people's neighbourhoods
  - Increased use of voluntary and community groups, organisations and services to support people during and after intermediate care and support

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing the immediate and medium-term impact of a non-elective hospital admission, helping people to rehabilitate and recover through a therapeutic-led care approach
- By providing proactive personalised care and support to help people regain their independence, confidence and ability to manage their own care and support at home
- By supporting carers and wider family networks to ensure people can stay at home in their communities for longer
- By reducing the likelihood of premature admission to residential care
- By ensuring people can access the appropriate health and care services in their neighbourhood (15 minute neighbourhoods) informed by the Marmot work in LBWF on health inequalities
- Through pro-actively connecting people with appropriate services once their intermediate care and support ends for example to voluntary and wellbeing services

Key programme features and milestones:

- **Discharge to Assess**
  Direct engagement in pre-discharge planning for residents and carers based on Home First principles
  Early supported discharge from hospital
  Care management and continued support post discharge for up to 6 weeks
  Access to specialist care and support in hospital and post discharge e.g. stroke
- **Rehabilitation, Reablement and Recovery**
  Dedicated in-patient rehabilitation outside of hospital#
  Therapeutic-led care approach to regain independence
  Access to appropriate assistive technology, aids and adaptations
  Free personalised reablement care and support for up to 6 weeks
- **Virtual Ward**
  Earlier discharge and admission avoidance through Clinician-led support Virtual Remote Monitoring
  Coordinated health and social care support for up to 14 days post discharge
- **Admission Avoidance**
  Coordinated assessment and referral for urgent care in the community
  2 hour response time for urgent care needs
  Care and support at home or in a step-up community bed to avoid admission

Further transformation to be planned in this area:

- Over the next two years
  - Increase of 27 WTE staff working in intermediate care
  - Increase of £1,681k of funding to support transformation
  - Aligning Home First with the IDF
  - Alignment to LBWF transformation i.e. 15 minutes neighbourhoods, Marmot review on health inequalities and Adult Social Care Reform
- Over years three to five
  - Increase of 39 WTE staff working in intermediate care
  - Increase of £2,426k of funding to support transformation

Programme funding: -£2,426k over 5 years

Impact over 5 Years:

Home First	Non elective admission reduction	389	779	1,168	1,168	1,168
	Bed days saved	3,276	5,995	8,714	8,714	8,714
	Beds saved	9	16	24	24	24
	£'000 saved	£1,624	£3,084	£4,544	£4,544	£4,544

Leadership and governance arrangements:

- Waltham Forest Health & Care Partnership Board
- Home First Executive
- Home First Operational Leadership Group

Key delivery risks currently being mitigated:

- There is a risk that if we are unable to continue to fund our discharge programmes that support the HF programme, then this will have a significant impact on ability to discharge people from hospital in a timely manner. Partnership discussions on funding for 2023/24. Likely Government will continue discharge support.
- There is a risk that we fail to engage staff in wider transformation and as a result we fail to deliver the new ways of system working. In 2023/24 both informal and formal engagement with staff will be a key focus as we further integrate teams and services

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Learning Disabilities and Autism / Waltham Forest Place-based Partnership / Sue Boon- sue.boon@nelft.nhs.uk

The benefits that Waltham Forest residents will experience by April 2024 and April 2026:

- April 2024:
  - Increased uptake of vaccinations amongst the population who have LD
  - Increased numbers of people with LD in employment
  - Reduced waiting lists for autism and ADHD in adults
  - Improved quality of annual health checks for people with LD
- April 2026:
  - Waltham Forest will be an Autism Friendly Borough and improved neurodiversity offer
  - Increased access to accommodation for people with LD and Autism

How this transformation programme reduces inequalities between north east London's residents and communities:

- By increasing uptake of vaccination for people with LD
- By improving quality of AHCs, we will reduce inequalities by identifying ill health earlier in this population
- By improving access to employment, this will improve the health, particularly MH, of this population
- By linking with the evidence and action plan of the Marmot Review

Key programme features and milestones:

- Specialist employment advisor for people with LD in post
- Specialist LD nurse for health inequalities in post
- Autism Strategy
  - Improving awareness and understanding of reasonable adaptations (inc. built environment)
  - Reviewing Education offer and support
  - Improving community safety
  - Targeting specialist training across health and social care

Further transformation to be planned in this area:

- Over the next two years
  - Link to 15 minute neighbourhoods
  - X
  - X
- Over years three to five
  - X
  - X

Programme funding:

- NEL LDA programme funding (as devolved to place)
- Investment and Innovation Funding for 23/24

Leadership and governance arrangements:

- Improving Life Chances Board
- Place Based Partnership Board
- Autism Strategy Board

Key delivery risks currently being mitigated:

- Workforce – issues in both MH and Primary Care
- Increased demand and acuity for services
- Ability to invest long term in areas that will reduce inequality whilst still trying to meet acute demand
- Lack of perceived priority by wider programmes often mean health inequalities are exacerbated and don't get prioritised

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Standard template: transformation in NEL - Wellbeing

North East London Health & Care Partnership

Wellbeing / Waltham Forest Places-based Partnership / Sue Boon- sue.boon@nelft.nhs.uk

The benefits that Waltham Forest residents will experience by April 2024 and April 2026:

- April 2024
- Increased access to information and advice
- April 2026 :
  - Reduction in health inequalities
  - Increased independence and feelings of wellbeing
  - Increased numbers of people playing active roles in their neighbourhoods

How this transformation programme reduces inequalities between north east London's residents and communities:

- We will use the Marmot research to understand the social determinates of health inequalities and develop solutions to address them
- We will use the data and insights gathered from communities to develop local networks and solutions to the issues that affect them.

Key programme features and milestones:

Understanding the needs of our population using :
- Population Health Management
- Community Insights
- !5 minute neighbourhoods

Providing Information, Advice and Guidance:
- Universal and Targeted
- Digital
- Face 2 Face
- Telephone
- Social prescribing

Health Promotion, Lifestyles and self care:
- Smoking Cessation
- Healthy Weight
- Others

Further transformation to be planned in this area:

- Over the next two years
  - Development of our assistive technology offer
  -
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

Health inequalities funding

Leadership and governance arrangements:

Establishing a local programme group which will feed into the Place based partnership board

Key delivery risks currently being mitigated:

There is a risk that we will not be able to shift resources from acute services into preventative solutions that promote wellbeing whist still being able to meet acute system demands

Alignment to the Integrate care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care	x	High-trust environment	X
Long-term conditions		Employment and workforce	x	Prevention	x	Co-production	X	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

NEL NHS Tobacco Dependence Treatment Programme / Strategy and Transformation / Hilary Ross, Director of Strategy, NHS NEL, hilary.ross1@nhs.net

The benefits that North East London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Improved access to stop smoking support through all trust inpatient and maternity settings.
  - new services supporting thousands of inpatients to stop smoking
  - Decreased risk of miscarriages for our residents.
- April 2026:
  - 100% inpatients and pregnant people attending trusts in NEL have smoking status recorded and offered accessible and effective support to help them to quit smoking.
  - Reduction in smoking related readmissions at 30-days by 12% from baseline.
  - Reduction in smoking at time of delivery.
  - Reduction in the number of miscarriages, stillbirths and other birthing complications.

How this transformation programme reduces inequalities between North East London's residents and communities:

- Adult smoking rates are high across most boroughs in NEL compared to England. Smoking accounts for half the difference in life expectancy nationally between richest and poorest, and is particularly prevalent in groups such as routine and manual workers and people with SMI. Action on tobacco will have a direct impact on reducing health inequalities in NEL.
- Providing support to 100% secondary care inpatients will capture groups that may be less likely to seek out services, such as patients who are homeless, increasing their access to stop smoking support.
- Providing support to pregnant people to quit smoking will reduce health inequalities, including inequalities in stillbirths and infant deaths, and longer term health outcomes for mother and child.

Key programme features and milestones:

- All trusts providing tobacco dependence treatment services to 100% of inpatients, which will lead to improved outcomes.
- All maternity services supporting pregnant people to become and remain Smokefree, whilst undertaking CO monitoring at all appointments.
- Develop robust patient pathways with community partners.
- All trusts recruit staff members into roles dedicated to delivering inhouse tobacco dependence treatment services.
- All trusts to establish Smokefree Committees and smoking in pregnancy meetings.
- All trusts to evaluate their services.

Further transformation to be planned in this area:

- Over the next two years:
  - Ensuring tobacco dependence services in trusts become business as usual (sustainable).
  - Tobacco dependence services supporting community SMI service users.
- Over years three to five:
  - Smoking prevalence decreasing in each borough, moving towards <5%.
  - Developing opportunities for building brief interventions and tobacco dependence treatment into pathways across NEL, through collaborations across local authorities, trust, primary care and ICB teams.

Programme funding:

- 22/23 £947k NHSE SDF allocation: inpatients + maternity
- 22/23 £383k from NHSE for Community SMI
- 23/24 TBC – awaiting confirmation from NHSE

(>90% costs are workforce costs)

Leadership and governance arrangements:

- Trust level Smokefree committees and Smoking In Pregnancy meetings.
- NEL Tobacco Dependence Treatment Programme steering group.
- NEL Population Health & Health Inequalities steering group.
- NEL Respiratory Clinical Network.

Key delivery risks currently being mitigated:

- Ensuring sustainability post the initial three-year programme mobilisation period.
- Yearly funding cycles by NHSE (and very late confirmation of funding).

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce		Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

NEL Homelessness Programme / Place Based Partnerships / Ellie Hobart, Deputy Director of Strategy, NHS NEL, ellie.Hobart@nhs.net

The benefits that North East London residents will experience by April 2026

Those that experience homelessness will ….

- **have better health and social outcomes – through improved access to primary care and community services including mental health and drug and alcohol services,**
- **no longer be discharged to the streets and access step down accommodation that supports onward support out of homelessness**
- **be supported to improve their health and to be able to take increasing responsibility for their own health and wellbeing**
- **have better transitions between settings with pathways that are joined up and focus on the individual and provide wrap around care and support**
- **have better pathways for young people at risk of becoming homeless due to poor health and/or adverse circumstances by identifying those at risk earlier and providing wrap around support and timely interventions**
- **have safer environments that promote physical and psychological wellbeing**
- **have more opportunities for getting involved in the design and delivery of services.**

How this transformation programme reduces inequalities between north east London's residents and communities:

- People experiencing homeless have significantly worse health outcomes & poorest access to services they face extremely elevated disease risks and mortality risks which are eight to twelve times higher than the general population. Average age of death is 30 years lower than the national average.
- We also know those that experience homeless are at higher risk of mortality from suicide compared to the general population and report a mental health difficulty.
- Prevalence of dental issues, chest pain, breathing problems, eye problems, skin and wound conditions are higher than the general public and they are more likely to experience asthma, TB, heart disease and Hep C compared to the general population. The homeless are more exposed to extreme weather events and by providing a better housing offer when discharged we can improve recovery rates and management of long term conditions.
- They also suffer from stigma and discrimination which limits access to the services they need. And there is a lack of awareness of healthcare system and entitlements

The NEL programme, which is in line with NICE guidelines, and will contribute to addressing this inequity by through improved access to primary care and community services including mental health and drug and alcohol services, ensuring people are not discharged to the streets, working in partnership with housing and social care to improve awareness of entitlements, and ensuring services are trauma informed and co-designed with those with lived experience.

Key programme features and milestones:

- Sustainable roll out of out of hospital care model April 24
- Consistent coding of homeless in PC and acute April 24
- Homeless dashboard in place Dec 23
- Development of homeless outcome framework April 24
- Outer borough preferred approach to PC access scoped Dec 23
- Consistent homeless health outreach model in place for NEL April 24
- Workforce: – increased access to trauma informed training Dec 23
- OOHCM community practice established July 23
- Live experience approach scoped and mobilised Dec 23

Further transformation to be planned in this area:

- Over the next two years
  - OOHCM expanded to B&D
  - Consistent provision of outreach
  - Primary care access improved in outer boroughs
  - Specialist health visitor provision in temp accommodation
- Over years three to five
  - Prevention programme for young homeless
  - Employment and housing opportunities through anchor programmes
  - Joint pathways for co-occurring conditions

Programme funding:

- TBC – NEL funding being sought through business case process
- Place based funding sits within place

Leadership and governance arrangements:

- Place Based Partnerships – homeless programmes
- NEL Population Health & Integration Committee
- NEL Population Health & Health Inequalities Steering Group (NEL Equity in Health Workstream)

Key delivery risks currently being mitigated:

- Financial risk – OOHCM funded through DHSC - lack recurrent investment combined with high inflation affecting sustainability of current provision – business case being drafted
- Workforce – recruitment and retention of specialist staff, highly stressful roles. Development of community of practice and access to training e.g. compassion circles / trauma informed care
- Stakeholder – set of complex relationships across NEL multiple stakeholders and potential fault lines as housing supply limited. Maintain relationships and ensure inc. as a priority area for addressing HI
- Housing supply limited and expensive – LA unable to provide adequate housing, greater partnership working to mitigate.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	x	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Anchors Programme / NEL and Place Based Partnerships / SRO TBC

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Increasing the number of health and care organisations that pay a London Living Wage
  - Increased support to local residents to access careers in health and care sector – workshops, events, clearer routes from training & education
- April 2026:
  - Significant reduction in health and care carbon footprint – therefore improving population health (see details of the net zero programme)
  - Better access to healthcare in a community setting
  - More local suppliers winning health and care contracts.
  - More local residents working in the health and care sector in NEL

How this transformation programme reduces inequalities between north east London's residents and communities:

- Widening access to employment opportunities, training and a providing routes into employment via work experience
- Embedding procurement for social value in our systems contracting and procurement processes
- Maximising the value of our buildings and land
- Supporting a greener and healthier future.

Key programme features and milestones:

- Convene, connect and collaborate how the ICS is delivering on the four workstreams
- Develop a collection of case studies to share anchor work
- Delivery of HEE funded projects in Q1 – Q2 2023/4
- Hosting the Primary Care Anchor Network (PCAN) Manager – first year of a new role funded by HEE
- Support the next steps from the system Cost of Living workshop and ensure learning is shared across relevant groups and programmes
- Agree ambitions for using our land & buildings to benefit local communities.

Further transformation to be planned in this area:

Over the next two years

- Raise visibility of the NEL anchor charter
- Collaborate with colleagues across London to develop an anchors monitoring and evaluation framework
- Sharing and learning from across London and nationally
- Scoping options for poverty proofing practice in NEL with the HI steering group.

Programme funding:

- Health Education England - £250,000. Allocated to workforce development and training programmes that contribute to aims of the anchor workstreams. Non-reoccurring.

Leadership and governance arrangements:

- NEL Anchor Steering Group
- NEL Population Health and Health Inequalities Steering Group.

Key delivery risks currently being mitigated:

- Strengthening programme at Place with NEL team
- Establishing a monitoring and evaluation framework in place for all of the anchor workstreams, without which we risk not effectively making progress against the NEL Anchor Charter.
- Securing a NEL lead for the Anchors procurement workstream. Without this we cannot track progress and implementation of how providers are meeting the 10% minimum on social value in procurement exercises.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	x	Health inequalities	x	Personalised care		High-trust environment	x
Long-term conditions		Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Net Zero (ICS Green Plan) / NEL/ Steve Collins, Director of Finance, NHS NEL, steve.collins5@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Access and encouragement to move to prescribed low-carbon inhalers
  - Cleaner air as a result of less staff commuting by car and switch to low emission fleet
  - Greater awareness of the green plan and net zero approach that healthcare organisations are making to reduce their impact on the environment
- April 2026:
  - Reduction in medicine waste
  - Better regulated heating within healthcare buildings and estates
  - Reduction and phasing out of single use plastics
  - Re investment of resources saved by reducing energy and medicines waste

How this transformation programme reduces inequalities between north east London's residents and communities:

- By taking climate action for our population we reduce the severity of climate change and increase the life chances of our population
- By taking climate action for our population we reduce the likelihood of developing as well as exacerbating long term conditions such as asthma
- By taking climate action for our population we will improve access to nutritious food and green spaces therefore improving health and wellbeing.

Key programme features and milestones:

Carbon Footprint - the emissions we control directly

- A 40% reduction by 2025
- An 80% reduction in the emissions we control directly by 2028-2032
- Net zero by 2040.

Carbon Footprint Plus - the emissions we control indirectly

- An 80% reduction in the entire emissions profile by 2036-2039
- Net zero by 2045.

Programme funding:

- Ad-hoc small pots from NHS England
- Seeking GLA funding for green spaces projects
- Breakdown across capital, workforce / care services, programme delivery

Further transformation to be planned in this area:

Over the next year

- Completely removing the use of volatile anaesthetic gases (11% reduction)
- switching all the combined electricity, gas and oil to renewable sources (41% reduction)
- Switching all MDI Inhalers (18% reduction)
- By switching NHS Fleet to electric vehicle and cycles (4% reduction)

Over years two to three

- We will improve the carbon literacy of hundreds of staff
- We will increase capacity in the system by improving the resilience and professional development of the staff delivering Trust and ICS Green Plans
- Review three year plan and create next net zero strategy.

Leadership and governance arrangements:

- NEL Anchor Steering Group
- NEL ICS Green Plan Strategy Group (meet bi-monthly)
- NEL Sustainability Working Group
- Various thematic sub-groups

Key delivery risks currently being mitigated:

- Identifying carbon footprinting experts to monitor how we will become net zero by 2040. If the programme is not able to monitor it's carbon footprint the Green Plan cannot monitor its progress or identify areas of concern.
- Need to identify resources to undertake adaptation planning and expertise. .
- Gap in resource to manage air quality programme – business case in development
- Economic risks due to a long term lack of capital investment, combined with current high levels of inflation affecting material prices for driving change.

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

NEL Refugees & Asylum Seeker Working Group / Place Based Partnerships / Ellie Hobart, Deputy Director of Strategy, NHS NEL, ellie.Hobart@nhs.net

The benefits that North East London residents will experience by April 2026

Those that experience refugee & asylum seeker (RAS) accommodation will have….

- better health and social outcomes – through improved access to initial health assessments, GP registration and care planning that will support access to primary care and community services to meet their needs
- improved access to social prescribing that aligns with primary care pathways - sign-posting people to local CVSF and providing opportunities to integrate into local communities and activities and supporting mental health
- smoother transitions with a health record that follows them and takes a trauma informed approach.
- coordinated and proactive safeguarding

How this transformation programme reduces inequalities between north east London's residents and communities:

- For **asylum seekers and refugees**, their health needs vary significantly but asylum seekers in Initial Accommodation Centres (IACs) and newly arrived refugees face inequalities in accessing health and care services. The programme aims to support access to funding that will lead to increased support to register with a GP and how to access and use the UK health system.
- The RAS cohort will likely face inequalities due to their limited resources concurrent to this they are also likely to require, language, material and social support. The programme is bringing together local authority and health care stakeholders that will be able to support joined up partnership approaches e.g. a highlighted inequalities challenge has been funding for travel expenses to health and care appointments.
- Another inequality being faced relates to not being 'visible' to the health and social care system in the first instance - It is difficult to track the hotels, dispersed accommodation and temporary accommodation in each local authority that is being used to house homeless households **and asylum seekers and refugees** and to therefore have an accurate picture of the homeless population at any given point in time and therefore support them with services. Improving shared data with the home office and housing provider alongside the correct and timely notification of health and social care providers will benefit those 'unseen' individuals.
- VCS organisations supporting the RAS cohort highlighted the inequality faced due to a poor understanding of how to access and navigate the system and fear of doing so. Inequalities due to this may be reduced via developing agreed and consistent information/ communication across the NEL partners e.g. contact points such as accommodation and GP practices

Key programme features and milestones:

- Establishment of NEL RAS working group in Sept 2022 – in response to place based partnerships seeking support for more co-ordination at a NEL footprint to the challenges of an increasing number of contingency hotels being set up in NEL.
- Improving key networks and establishing stakeholder relationships across place based partnerships and regional / national bodies e.g. GLA, UKHSA etc
- Scoping of 4 key 'priority' areas of NEL focus (primary care access/ safeguarding, data & data sharing, health protection)
- Development of generic NEL wide outreach specification for PC and implementation July 23
- Creating space to share learning across NEL

Programme funding:

- TBC – Potential NEL funding to be sought via business case related to Health Inequalities
- Place based funding potential sits within place

Further transformation to be planned in this area:

- Over the next two years
  - Coproduce outcomes for RAS population that align to our four work programme areas with system Place stakeholders
  - Support the place based partnerships in delivering against the four priority areas,
  - Forge improved relationship with home office and accommodation providers in order to improve health and care of cohort
  - Align to anchors charter and develop opportunities for employment in health services for RAS population
- Over years three to five
  - Enable improved access to dental, pharmacy and ophthalmology for this cohort
  - Implementation of national/ regional clinical templates for consistent capture and coding of asylum seeker status and assessments
  - Strategic approach to consistent best practice in the provision of welfare and wrap around support by local authorities for home office accommodation residents

Leadership and governance arrangements:

- Place Based Partnerships – local leads both LA and NHS
- NEL Population Health & Integration Committee
- NEL Population Health & Health Inequalities Steering Group (NEL Equity in Health Workstream)

Key delivery risks currently being mitigated:

- The unknown timelines, location and quantity of hotels being stood up by the home office at short notice is the largest risk. Linked to this are the unknown numbers of individuals expected to be accommodated at each site.
- Financial risk –lack recurrent investment combined with high inflation affecting sustainability of current provision i.e. £150 per person getting registered with a GP with no government funds to support initial health outreach services.
- Workforce – recruitment and retention of specialist staff, highly stressful roles.
- Stakeholder – set of complex relationships across NEL and lines of responsibility and accountability due to multiple stakeholders including Clearsprings Ready Home and the Home Office.

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	X	Personalised care		High-trust environment	X
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

NEL Discharge Pathways Programme / Nina Griffith, Workstream Director, NHS NEL nina.griffith@nhs.net

Overview: Across north east London, all places are working to improve discharge. The aim is to ensure faster discharges and that people are being moved into the correct place to support their needs. Although discharge is place based, there are some common approaches across the ICB, this includes:

- Encouraging a home first approach
- Continued improvement of the transfer of care hubs
- Promoting independence and reablement

City and Hackney: Hackney council has commissioned PPL to conduct an evaluation of the discharge infrastructure and pathways for the Homerton hospital. The diagnostic phase and future planning process has started and will conclude at the end of March 2023. The output will be a shared understanding of successes and challenges across the local system with focus on areas of opportunity. This process will develop a vision for change with a project plan with clear performance targets and a framework to measure performance.
Tower Hamlets: Development of a single streamlined discharge model moving away from the current 3 team model.
Newham: Appointing a single Head of Discharge for Newham, managing the joint team.
Waltham Forest: Implementing the Home First Business Case including developing integrated rehab and reablement provision.
TNW: Delivery of the Newton recommendations ensuring we have Advance Care Planning, Imbedding Discharge to Assess, reduction in use of step down provision, improved use of Intermediate Care and using digital tools to ease discharge process.
Barking and Dagenham, Havering and Redbridge: BHR have reviewed reasons for discharge delay and have set up 3 task and finish groups focusing on discharge to assess home, review of the integrated discharge hub and review of rehab pathways.

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Reduction in delayed discharges
  - Increased number of people being discharged home
  - Reduction in readmissions due to poor discharge planning
  - Reduction in use of step down provision
  - Reduction in delayed discharges in hospitals of Out of Area (outside borough) residents.
- April 2026:
  - Continued improved against the benefits seen by April 2024
  - Increased number of people accessing reablement and living independently post-discharge

Programme funding:

- Overall sum and source: in 2023/24, NEL ICB will receive £12m from a pot of £600m as part of UEC recovery plan

How this transformation programme reduces inequalities between north east London's residents and communities:

- This programme works to identify areas of improvement across the different places by sharing of learning, for example, we are working to understand what is being funded in each place for each D2A pathway and IDH. Furthermore, we are continually working to improve performance against the BCF metrics related to discharge.

Key programme features and milestones:

- Focus on reducing delayed discharges
- Focus on reablement and supporting people to live independently
- Focus on home first approach

Key delivery risks currently being mitigated:

- Financial risks, particularly if funding is reduced
- Workforce risks particularly in the care sector, there are workforce improvement and recruitment projects in each place

Further transformation to be planned in this area:

- Over the next two years
  - Focus on transfer of care hubs
  - Focus on delayed discharges
  - Focus on improving discharge processes
- Over years three to five
  - Focus on reablement and supporting people to live independently post-discharge
  - Focus on shifting the culture on discharge

Leadership and governance arrangements:
The discharge programme is primarily delivered within the places. Within each place, there is a mobilised programme that is led by one or more of the following:

- Local authority leadership via DAS
- Hospital leadership via COO or equivalent
- ICB leadership via Head of Age Well or Place Director

Oversight is maintained at NEL level via the NEL discharge group and regular assurance is provided to NHSE.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Pharmacy and Medicine Optimisation/ NEL / SRO:Dr Raliat Onatade, ICS Chief Pharmacist and Director of Medicines and Pharmacy NHS NEL- raliat.onatade@nhs.net

The benefits that North East London's residents will experience by April 2024 and April 2026:

April 2024:
- All eligible residents particularly those in areas of social deprivation and/or on low income will have equitable access to medications for minor ailments for self-care without needing a prescription.
- Patients will be supported to self-manage certain minor illnesses without the need of seeing a GP
- Better management of their health especially with self-care of minor conditions by community pharmacies is an opportunity to solve GP appointment crisis and drastically improve patients' access to general practice
- Reduce the number of GP appointments and/or A&E attendance for conditions related to specific minor illnesses and ailments
- Freeing up GP appointments will lead to reduced work load on local GPs and increased access for complex patients being seen in a timely manner and hopefully decreased NHS waiting times.

April 2026:
- All residents with a minor ailment will have rapid access to medicines for self-care and advice to empower them to manage their own condition effectively and avoid repeated GP or A&E attendances
- Improve access to prepayment certificates for patients with a long-term condition and those requiring occasional medications
- Personalised care - population Health and primary care Management to support cohort identification and quality care interventions delivered through implementation of NEL LTC outcomes framework

How this transformation programme reduces inequalities between north east London's residents and communities:
- Through the reduction of additional inequality in health outcomes between residents who are financially challenged. Residents in more deprived areas were less likely to collect their medication for self-care due to the cost of the medications
- By reducing unwarranted variation in access to over the counter (OTC) items free from the pharmacy for self-care of minor ailments (currently only residents across C&H were receiving this within NEL)
- The impact of increased appointments for prescriptions of OTC medicines for minor ailments (by patients who cannot afford to buy OTC medicines for self-care) on local GPs would result in some complex patients being unable to access urgent GP appointments or seen in a timely manner

Key programme features and milestones:
- Business case developed for NEL ICB – April 2023 –
- Ensure equitable access for identified cohorts of eligible patients to obtain over the counter (OTC) items free from the pharmacy for self-care including homeless, refugees, asylum seekers (Q1 23/24)
- Establish robust primary care engagement with all key stakeholders including LMC and LPC to improve patient outcomes and experience (Q1 23/23)
- Evaluation and targeting uptake in identified underserved populations (Q1 23/23)

Further transformation to be planned in this area:
Over the next three years
- To provide access to prepayment certificates for patients with a long-term condition and those requiring occasional medications. (TBC 2023)
- We recognize this scheme may be unaffordable in this financial year but will be considered in the next year.

Programme funding:
- None. Likely Health Inequalities (NEL wide shared ambition) or cross borough with place based partnerships programmes of work.
- An annual recurrent funding of £1,569,645.93 is required.

Leadership and governance arrangements:
- Clinical leads (pharmacy and Medicine optimisation and primary care)
- Working groups – Quality, Insight, Finance. Comms, Contract , PMO leads
- Cross working across place Based Partnerships

Key delivery risks currently being mitigated:
- Funding- concerns around recurrent- funding required for the scheme
- ICB workforce sustainability – uncertainty around FTC roles due to the consultation – not mitigated

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health		Health inequalities	x	Personalised care	x	High-trust environment	
Long-term conditions		Employment and workforce		Prevention	x	Co-production		Learning system	

North East London
Integrated Care Board

NHS North East London ICB Board

29 March 2023

Title of report	Financial Strategy
Author	Steve Beales Assistant Director – ICS Implementation
Presented by	Henry Black, Chief Finance Officer
Contact for further information	Steve Beales steve.beales@nhs.net
Executive summary	The proposed financial strategy for north east London was endorsed by the Finance, Performance and Investment Committee (FPIC) on 6 January. The strategy has been used to guide a number of system processes, including our financial allocations approach, operational planning and the development of our Joint Forward Plan. Through these processes we have tested and refined the implications of the strategy and this is now being brought back to the Board for formal sign-off.
Action / recommendation	The Board are asked to note the report and endorse the approach.
Previous reporting	Finance, Performance and Investment Committee and ICB Board. Discussion at various forums including: NEL CFO Leadership Forum; ICS Strategy Task and Finish Group; all seven place partnership boards; NEL Executive Leadership Team.
Next steps/ onward reporting	N/A
Conflicts of interest	There are no conflicts of interest.
Strategic fit	The ICS aims this report aligns with are: • 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 framework described aims to improve health and care outcomes for NEL residents through changes to funding arrangements. No equalities impact assessment has been undertaken.
Impact on finance, performance and quality	The report describes our policy intent as a system. While there are no direct additional resource implications, it does discuss how existing resources will be better managed.
Risks	Partners need to be bought in to the new approach to ensure that it is successful. We have carried out extensive

	engagement on proposals and will continue to work with partners to support new ways of working.

1.0 Introduction

1.1 NHS NEL has, with system partners, developed a financial strategy for north east London. The strategy seeks to guide our approach over the coming years. In January 2023 the NHS NEL Board endorsed the draft strategy.

1.2 Through the current (annual) operational planning process some elements of the financial strategy are being built into our financial framework for 2023/24 – further detail provided below – but the full implications of the financial strategy will likely take a number of years to take effect.

1.3 The approach described represents a significant shift in the way funding is allocated across north east London and seeks to support our twin goals of financial stability and supporting all organisations and partnership forums to transform and improve services for our population. The approach will support the Integrated Care Partnership's five-year strategy and allocate resource in line with that strategy.

2.0 Context

2.1 The NHS is still recovering from the most acute phases of the covid pandemic, with increased demand for urgent and emergency care; a substantial backlog for elective care and a substantial underlying financial deficit across the ICB and trust partners. Workforce shortages and a cost-of-living crisis among many staff further compound these pressures.

2.2 The system is reporting an unadjusted deficit of £35m for 2022/23 (prior to receipt of additional NHSE deficit support funding) but the underlying position is in excess of £100m. NEL also receives a significantly lower capital allocation than other ICSs nationally. This is due to the way the allocation formula treats retained depreciation and PFI assets, both of which significantly disadvantage NEL.

2.3 NEL contains some of the most deprived areas in the country and our population has already grown substantially over the last few years. Further significant growth is expected over the coming years (for instance, we have 18,000 new homes being built in Barking Riverside alone). Without changes to care models we expect that over the next 5 years this translates to: A&E activity increasing by 12% (costing an extra £16m); inpatient activity increasing by 16% (costing an extra £131m); outpatient activity increasing by 15% (costing an extra £43m); and imaging activity increasing by 17% (predicted extra cost currently unavailable).

2.4 The legislation that came into force on 1st July 2022 has some helpful implications for how finances work within north east London. A key change is that ICBs and their partner trusts must (collectively) ensure that they are delivering a balanced financial system each year. There is also a duty on all NHS organisations to consider the wider impact of their decisions and in reference to the NHS triple aim.

2.5 We hope to use the legislative changes, along with the more collaborative ways of working developed during covid and fostered since, to create a new financial framework within north east London. One which supports collective stewardship of resources as a partnership, enables mutual accountability for maximising value for

money, and where all partners are supported and incentivised to improve the health and wellbeing outcomes of our residents.

2.6 We are trying to achieve financial stability over the short to medium term – recognising the significant challenges the system faces this year and next – while also ensuring that we have a sustainable model over the medium to long term, by beginning the transformation of services now so that services are not overwhelmed by future demographic growth.

3.0 Agreed ambitions of our new financial framework

3.1 Our new financial framework will need to iterate over time as we 'learn by doing' and we recognise that much of what we are describing here is the NHS NEL part of a wider system financial framework and we are keen to work with partners to develop it further.

3.2 We have a number of ambitions for what we want the new financial framework to help us achieve. These are aligned to our system design principles and include:

- Improving quality and outcomes for residents by
  - **Incentivising transformation and innovation** in clinical practice and the delivery of services to improve resident outcomes
  - Supporting delivery of **care closer to patients' homes**, specifically investing resources in services that take place outside of the hospital environment to reduce demand for acute and specialist services
- Securing greater equity for our residents by
  - Refocusing how the system spends its money **to focus on population health**, including proactive investment in measures that keep people healthier
  - **Increasing investment in prevention**, primary care, earlier intervention and the wider determinants of health, including environmental sustainability
  - **Levelling up investment** and addressing any historic anomalies in funding distribution
- Maximising value for money by
  - Supporting our providers to **reduce transactional costs, improve efficiency** and reduce waste and duplication
  - **Supporting the financial stability** of our providers and underpinning a medium-term trajectory to financial balance for all partners
  - **Recognising existing challenges**, including that NEL is, as a SOF 3 ICS, financially challenged with a growing population and an acute provider (BHRUT) in SOF 4 for financial performance.
  - Ensuring we do not **create unnecessary additional financial risk,** especially in the acute sector
- Deepening collaboration between partners by
  - Supporting the **integration of health and social care** for people living with long term conditions who currently receive care from multiple agencies
  - Ensuring that all partners are able to **understand and influence** the total amount of (ICB) resources being invested in residents' care.

4.0 Our future financial framework

4.1 We face significant operational and financial pressures within NEL, in particular due to growing demand for acute care. These pressures are expected to grow (if not tackled) due to substantial population growth and our ageing population.

4.2 To support the changes we need to make as a system to deal with these pressures and enable the system to have the capacity to redesign care, we plan to create an investment pool for transformation focused on dampening future demand for acute care.

4.3 Following collaborative discussions with CFOs across the system, growth assumptions have been applied at a contract level of 50% of national assumptions. This has created an investment pool for 2023/24 of £22.9m. In 2023/24 this pool may also need to be used where we have unfunded commitments, but our ambition for later years is to increase the size of the investment pool (to 1% of the NHS NEL budget received from NHSE) and to ensure that it is more closely targeted at truly new transformation/services.

4.4 Remaining revenue allocations (and associated savings requirements) will be made to place committees of the ICB (which operate in close alignment with the wider place partnership in each place), to trusts, or be held centrally by the ICB.

4.5 We will use the following two principles when determining which budgets, for which services, can sit with different parts of the system:

- Trust partners (NELFT, ELFT, Barts Health, BHRUT, Homerton and London Ambulance Service) should hold and manage budgets for the care they provide and should receive “block payments” directly from NHS NEL to cover the majority of this care, with a variable payment to cover elective care (in line with national requirements).
- For non-trust budgets the default assumption is that place committees (on behalf of place based partnerships) hold budgets, unless coordination/planning for the services concerned is best done over a larger footprint (in which case they will either be held by the ICB centrally, or by one of the place committees on behalf of several).

4.6 We are moving from a model where we pay our trust partners to deliver specific services, to one where we fund partners, in a way that recognises the costs they bear, to improve health and wellbeing outcomes for our residents. This increases the importance of transparency between partners and, in particular, the visibility of budgets and how they are utilised (including costing information).

4.7 The principles recognise the substantial fixed costs held by our trust partners and that the best way to ensure that trusts take shared responsibility for the population of NEL is by ensuring that they are able to engage in discussions about services and transformation without worrying that funding will be stripped away without their consent and appropriate plans for the services concerned.

4.8 The principles also recognise that place based partnerships are becoming the engine for driving change within our system and that giving them as much budgetary flexibility as possible will help them to consider the wider determinants of our population’s health, while finding ways to support and strengthen primary care services.

4.9 To that end, allocations will be made to trusts and place committees on the assumption of active and meaningful engagement with partners – through the place committees and the broader place based partnerships and through the provider collaboratives – and that partners will actively support the design and implementation

of plans to redirect resources, over time, in the best interests of the population, absent of organisational self-interest.

4.10 We will work with partners to agree the specific budgets for which place committees will have responsibility and the associated requirements (such as reporting and treatment of over/under-spends) as part of the ongoing development of the Mutual Accountability Framework (MAF). Our intention is that place committees will take on these responsibilities during the 2023/24 financial year (potentially at different points in the year for different places), with all places responsible for delegated budgets ready for the 2024/25 planning round.

4.11 We have underlying deficits across the system and particularly within Barts Health and BHRUT that we need to recognise and eliminate as a system through improved productivity and more efficient use of the resources currently allocated to acute care. National efficiency requirements will be passed to trusts, on the expectation that they will work together, through their provider collaboratives, to deliver the improved productivity and how they will deliver the 'convergence' savings, recognising that this may require wider system solutions.

4.12 Trusts will be asked to ensure productivity (technical efficiency) is at a sufficient level that, as well as delivering on efficiency targets, it enables them to (over the medium term) return to financial balance. Trust partners are already working together – for instance work on the Drivers of the Financial Strategy – to identify how best to deliver productivity improvements, and will determine which programmes, organisations and sites will be responsible for delivering the savings needed.

4.13 Funding will be allocated in line with the ICP's five-year strategy, ensuring that we increase our investment in mental health services in line with the mental health investment standard (MHIS) requirements – an existing commitment – and increase the proportion of our budget spent on early intervention and prevention[1] – a new commitment for 2023/24. In 2022/23 £446m was spent on primary care and £351m spent on community care by NHS NEL.

4.14 There are currently differences in the services offered and funding available for different populations across north east London. To avoid the negative consequences associated with withdrawing funding from existing effective services, our approach to reducing funding and service inequities is to use additional funding due to growth and more discretionary funding wherever possible. This will initially focus on areas where there are identified gaps in core service provision. We will review what this core service provision should be and how we will meet its financial implications. Longer term we will co-develop with partners an agreed approach/formula for determining where we direct new/additional funding within the system, based on an assessment of population need and existing provision.

The board are asked to publicly endorse the approach described.

[1] At this time we do not think we can go as far as committing fully to a recommendation made in a report by Michael Marmot's Institute of Health Equity that was commissioned by Waltham Forest partnership that suggested we "Benchmark NHS and local authority prevention spend in 2022–23 and increase funding for prevention by 1 percent above inflation each year for the next 10 years to address inequalities in the social determinants."

5.0 Partnership working and greater transparency

5.1 The financial framework seeks to support system aims, including being an enabler to effective discussions – within Place based Partnerships, within provider collaboratives, and between the two – about the transformation of services.

5.2 This will require partners to take collective stewardship of resources, operating shared/virtual budgets that are based on the aggregate spend of relevant partners.

5.3 Decisions to do something different with collective resources are made through agreement and based on demonstrable evidence (rather than a unilateral commissioning decision). All partners have equal status in determining priorities, agreeing actions and collectively living with the consequences.

5.4 Partners can agree to move money between themselves (to reflect movement of services and changing cost bases), but they can also agree to utilise capacity in different ways between partners, without the need for changing how money flows.

5.5 We are working with partners in each place based partnership to support the development of whole-partnership shared/virtual budgets. These currently include NHS NEL's spend on the place's population alongside that of the local authority.

5.6 There is more work to do to increase the usefulness of shared/virtual budgets – including widening the sources of information (for instance looking at spend on the wider determinants of health) and being able to draw a clearer line between the money spent and what it is actually used for (the workforce and estate, etc). We also need to improve our understanding, in particular with trust partners, of costs (rather than ICB spend). This will require trusts to better understand their own costs (e.g. through service level reporting) and how these break down across different populations. However, this is not just a technical exercise and will require trust and openness between all partners.

5.7 We will work with partners to ensure that financial information is also built into population heath management (PHM) models that provide a firmer link between the cost of interventions and the impact on health and wellbeing outcomes of our residents.

6.0 How the ICS investment pool will operate

6.1 For the 2023/24 financial year the investment pool will be £22.9m.

6.2 Of this money £6.6m will be allocated for tackling health inequalities – this matches the funding made available to the ICS in 2022/23 from a national pot for tackling health inequalities in line with the CORE20PLUS5 national framework. As in this year, we would expect to see this health inequalities funding flowing to a range of local partners including the community and voluntary sector.

6.3 For the remaining budget (£16.3m) the process for allocating funding will be through a rapid cross-system exercise and we have asked all system partners – through Collaboratives, Place Partnerships and organisations – to identify key unfunded growth asks for the financial year 2023/2024.

6.4 It is vital that the opportunity to use other funding routes has been considered and exhausted before consideration of funding from the investment pool – this is in light

of our need to work as a system and to ensure our mainstream budgets contribute to our existing pressures as there is insufficient growth to identify new sources of funding for each pressure.

6.5 A constructive challenge process will, therefore, be built in by using the long list to assure ourselves we are using our funding to best effect across the system and meeting pressures through funding already identified and agreed wherever possible.

6.6 Schemes that do not receive funding at this stage (noting that we expect the total ask to be significantly greater than we can fund) will form part of our future pipeline, to be re-considered as and when further funding pots become available or in future years.

6.7 Developing a pipeline for us into the future is an important way for us to understand how we can optimise the significant resources we have available to us, whilst recognising where we may need to work differently and make efficiencies. Involving local people and wider partners (including the voluntary, community and social enterprise sector) in this pipeline development and prioritisation process will be an important part of us changing how we work as a system.

Detail on the schemes being supported and those entering our pipeline will be brought back to the Board for information.

7.0 Finance development programme

7.1 To ensure that we begin to make the changes in our financial framework that we need to support our new ways of working, we are keen that the proposals described above are agreed by the system and begin to inform how we work in 2023/24, but we do recognise the major shift these changes represent and that for NEL to operate effectively going forward, a wider development programme is required, and that all parts of the system will need some support to work in these new ways going forward. This programme will include:

Develop virtual budgets for each place

- Work is underway with each place based partnership to support the development of whole-partnership shared/virtual budgets. These include NHS NEL's spend on the place's population alongside that of the local authority. They provide an overview of budgets and of expected spend vs actual, updated monthly.
- Extend the information held within shared/virtual budgets to include more information from other partners, and more accurate estimates from trusts, NHS NEL and local authorities.
- Support places through the establishment of Finance and Planning Forums (or equivalents) in each place which enable partners to share their budgets and spend with each other, to better understand performance and impact, to understand joint programmes and differences in approach and to plan for changes in models of care

Agree place budget delegation

- Work with partners to agree the specific budgets for which ICB place sub-committees will have responsibility and the associated requirements (such as reporting and treatment of over/under-spends) as part of the ongoing development of the Mutual Accountability Framework (MAF). Our intention is that place sub-committees will take on these responsibilities during the 2023/24

financial year (potentially at different points in the year for different places), with all places responsible for delegated budgets ready for the 2024/25 planning round.

Develop our funding formula/approach

- Co-develop with partners an agreed approach, including a formula or set of formulae for determining where we direct new/additional funding within the system, based on an assessment of population need and existing provision.

Benchmarking and business intelligence

- Develop a suite of reports/tools that support discussions between partners within places about the best allocation of capacity. Includes benchmarking of finance and performance/operational data. Supports transparency within and between places.

Improve our costing approach and visibility

- Work with trust partners to improve costing information (including SLR) and to increase visibility of costs and capacity among partners.
- Improve visibility of non-trust contracts held by the ICB and the services/capacity they cover.

Specialised commissioning

- Ready for delegation from NHSE, build specialised commissioning budgets into place shared/virtual budgets and develop our understanding of how spec comm spend can be reduced through earlier intervention.

Contracting and procurement

- Develop options for contractual arrangements (or alternatives) that can support the pursuit of joint outcomes by partners – e.g. risk-share arrangements – recognising the different approaches to commissioning and contracting in place across the system.
- Develop our procurement strategy to embed social value as a core component and ensure that contracting and procurement are anti-discriminatory (in particular ensuring processes are anti-racist) and enable a more level playing field for VCSE sector.

PHM

- Work with partners to ensure that financial information is built into population heath management (PHM) models that provide a firmer link between the cost of interventions and the impact on health and wellbeing outcomes of our residents – enabling patient pathway mapping and to help us understand the real (system) cost of different population groups.
- Develop a pilot that considers a small, high-cost patient cohort in an area, bringing together linked data and experts to consider how we could, as a system, do better with those patients and our (collective) resources. Pilot would help to build our understanding about what the big cost drivers are across the system; support the development of data sources (and analysis), as well as identify changes to care pathways that could be used to redesign care elsewhere in the system – for instance where patients are being seen in inappropriate (and/or unnecessarily expensive) settings.

The board are asked for views on the work areas described.

NHS
North East London
Integrated Care Board

North East London Integrated Care Board

29 March 2023

Title of report	Deep Dive: Urgent and Emergency Care (UEC)
Author	Clive Walsh, Interim Director of Performance
Presented by	Dr Paul Gilluley, Chief Medical Officer
Contact for further information	Clive Walsh clive.walsh2@nhs.net
Executive summary	The following report provides an overview of urgent and emergency care across North East London and how the system is managing pressures and challenges as well as identifying solutions as a system in a number of key areas.
Action / recommendation	The Board is asked to note the report and comment on the next steps set out in section 7.
Previous reporting	Performance reporting on UEC at Finance, Performance and Investment Committee.
Next steps/ onward reporting	NEL ICS UEC Programme Board, 5 April 2023
Conflicts of interest	None
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money
Impact on local people, health inequalities and sustainability	This paper includes information on local people's experience of and response to the provision of UEC locally. Further work is required on health inequalities.
Impact on finance, performance and quality	There are multiple improvement plans and reviews in place for UEC that will have financial implications. The delivery of the 76% 4-hour treatment standard in March 2024 will require investment in capacity. This is part of the 23/24 Operational Plan
Risks	The risks to delivery of UEC performance are staffing and poor flow throughout the system leading to people not always being supported in the right part of the system at the right time

	There have been a series of days of industrial action, some elements of which may continue. There is a quality and reputational risk with regard to the CQC assessment of UEC.

1.0 Introduction

1.1 This paper sets out the scope of Urgent and Emergency Care (UEC) services and the current issues facing the Board and providers in ensuring that timely and high-quality services are available for residents. The actions and processes to respond to these issues are included. There are existing governance structures for UEC within the north east London ICS, which were developed through extensive consultation in 2022. The delivery vehicle for performance and transformation plans is the ICS UEC Programme Board, chaired by the ICB Chief Medical Officer. There are several complementary improvement processes and programmes underway, these are co-ordinated and assurance is obtained through the Programme Board.

1.3 There are commonly used definitions for UEC, published by NHS England:

- Urgent care involves any non-life-threatening illness or injury needing urgent attention which might be dealt with by phone consultation through the NHS111 Clinical Assessment Service, pharmacy, primary care. As an illustration of volume, there are around 30,000 patient contacts with primary care in NE London every day, many of which would fall into the urgent care category
- Emergency care involves life-threatening illnesses or accidents which require immediate treatment from the ambulance service (via 999) and an emergency department (A&E). There are some highly specialised and centralised emergency services such as major trauma and hyper-acute stroke service where volumes are much smaller.

1.4 The urgent and emergency care system in north east London therefore encompasses all of primary care, urgent treatment centres, emergency departments as well as 111 and London Ambulance services. The system is extremely interconnected - we know that for instance people who are unable to obtain an urgent appointment in primary care will often then visit hospitals to obtain the care they need. Improving the access and experience of local people in urgent and emergency care therefore requires a response at every level of the system.

1.5 We acknowledge some significant areas for improvement across the scope of urgent and emergency care in response to demand pressures and to shortcomings identified through recent Care Quality Commission inspections. We are committed to working together as a system and with local people to respond to all the challenges identified in sustainable ways and with a focus on concrete improvement.

2 National UEC recovery plan

2.1 On 30 January 2023 a national UEC recovery plan was published, which sets out the NHS performance aims in this area for the years 23/24 and 24/25. This was in response to declining timeliness of care over several years, accelerating after the advent of the COVID-19 pandemic. The key measures of success in the national plan are:

- A response time to category 2 ambulance calls of 30 minutes

- 76% of patients to be treated and discharged or admitted through Emergency Department (ED) within 4 hours

2.2 The operational plan for 2023/24 is required to set out how the system will deliver these targets. The plan also requires us to develop plans for a capable and responsive System Control Centre (SCC) for the ICB, which is currently provided in virtual form, in conjunction with North Central London. Currently, many sources of data exist and it is used in disparate ways. As a first step, work has begun to assess data sources, quality and completeness, and consideration is being given to potential uses of current commercially developed platforms to enable the future SCC to predict system pressure and clinical risks.

3.0 The voice of local people

3.1 Whilst the national recovery plan sets important targets for us to work to, it is important that we understand how to ensure that local people in north east London access this care in ways that work for them and improve outcomes. Through the Community Insights System led by Healthwatch we have gathered local people's views from across north east London on their experiences of trying to access and use all parts of urgent and emergency care. We have in-depth insights through the GP Access Survey, for example, into people's experiences of and preferences in accessing primary care. Most recently, work by Healthwatch on Urgent and Emergency Care and on experience of the London Ambulance Service identified the waiting time in Emergency Departments and the wait for an ambulance, once requested, as the two areas of highest concern to residents.

3.2 Some local people tell us that they struggle to get urgent GP appointments which can lead to diminished trust in their GP even once advice is given – their experiences help us to understand how the system works in practice. We know that the reasons for people's behaviour are complex and not always linked to a single cause. For example, a patient advised after a telephone consultation with a clinician to stay home and take paracetamol may not trust that this is the best course of action and may make a number of decisions about what to do next. We can also see trends in the responses to different people giving advice – a member of administrative staff advising a patient to call 111 or go to their local Emergency Department may be seen as refusing care on the GP's part rather than acting in their best interests. The wealth of data and insight we have across the system is enabling us to work on identifying system issues, and ultimately solutions. This work cross-refers to the required response to the Fuller report (section 4).

3.2 The NEL Quality, Safety, and Improvement (QSI) Committee considered the issue of patient engagement as part of its review of Resident access to UEC at its meeting on 8 February 2023. The follow up was agreed to take place through the UEC Programme Board.

4.0 Improving same day access in the community

4.1 The Fuller report set out the importance of ensuring that people can access urgent care in the community as well as receiving sustained continuity of care, including through integrated neighbourhood teams. London has traditionally been better served for urgent appointments in primary care than other parts of the country through additional out of hours primary care capacity. In north east London, GP Access Hubs manage same day urgent care within primary care, in part to reduce

the pressure on Urgent Treatment Centres (UTCs) and Accident & Emergency (A&E). In some of our places other services are available – for instance Duty Doctor in City and Hackney - and these have been very effective at support access and reducing pressure on other parts of the system. Central funding for GP Access Hubs comes to an end this financial year.

4.2 The ambition in NEL is to create a single integrated urgent care pathway in the community that is reliable, streamlined and easier for patients to navigate. This will require a resilient infrastructure and at the moment, same day access in the community is hindered by lack of capacity, which is being quantified as part of the 23/24 Operational Plan.

4.3 An integrated approach to reducing demand in urgent care is required and ensuring that patients are seen in the most appropriate setting for their condition. By addressing these needs as a system, the NEL response to the Fuller report will:

- Streamline the same day access pathway to ensure local people has access to the right service, received the right intervention in the correct setting
- Provide a service that is responsive at the first point of contact, enabling people to get on the right pathway
- Ensure everyone can access a universal service offer, no matter where in NEL you live
- Expand direct access and self-referrals to community services where GP intervention is not clinically necessary
- Tailor access points based on local people's needs and requirements
- Continue on the trajectory to deliver more appointments in general practice
- Tailor communication and engagement with local people

4.4 An ICB workshop on same day access across the system took place on 21 March 2023, and the outcomes will inform the future plan. The national primary care access recovery plan is expected to be published in March 2023.

5. System resilience

5.1 In order to function effectively our urgent and emergency care system requires all parts to be functioning effectively, and to be able to do so under the waves of increased demand typically experienced in winter but also in response to other pressures (such as industrial action). The winter of 2022/23 was extremely challenging and as a system we learnt a lot about how we need to work together. The recent industrial action has also provided valuable learning for how we can work differently and better. Flow through our system, and particularly our hospitals is an important component, as is discharge into the community and avoiding admissions initially. We were supported this winter through additional discharge funding and a proportion of this funding will also be available next winter. We will undertake a piece of work to capture the learning from this winter and put in place an improved system resilience plan for next winter. We are working with social care colleagues to ensure the best use of discharge funding and to understand better our demand and capacity as a system.

6. Outer North east London urgent and emergency care – CQC inspection of BHRUT and PELC and system wide improvements

6.1 Urgent and emergency care in outer north east London has been challenged for some time. A CQC inspection took place in November 2022 at BHRUT focused on urgent and emergency services. This was a follow up to a visit in November 2021 where issues were identified with flow, in and through, the urgent and emergency care pathway. In November 2022 all four urgent treatment centres provided by the Partnership of East London Cooperatives (PELC) were inspected along with both emergency departments and medical care provided by BHRUT. The inspections identified a number of significant issues and as a system we took part in a quality summit with CQC and NHSE in December to look at how to collectively address these.

6.2 A brief summary of the key findings

BHRUT - The CQC found that the trust faced continued challenges with access and flow into and out of the emergency pathway did not always receive timely treatment when needed and were not always cared for in the best place for their treatment needs. Waiting times in Queens and King George's hospital were also exacerbated by long waits for mental health patients and these patients had to wait too long to receive the right care.

PELC UTCs - all four UTCs were rated as inadequate and enforcement actions were issued. Inspection findings covered areas such as access to care and treatment in a timely way, a need to improve governance and accountability, a need for clearer vision and strategy and leadership capacity and skills.

6.3 In response to the CQC report, a quality summit was convened by NHS England in December 2022, bringing together system partners to agree a series of actions to address all aspects of the CQC findings. In relation to PELC actions included: robust contract management through quarterly contract performance, establishing a PELC Improvement Group, formed from relevant partners and looking at the improvement required across the BHR footprint. An exploratory conversation with Herts Urgent Care (HUC) regarding the possibility of being an Improvement Partner for PELC. Establishing a PELC Assurance Group attended by the ICB Quality Team and chaired by Fiona Smith, Associate Non-Executive Director of NEL. A focus on governance - the Good Governance Institute has been asked to provide external support in undertaking a governance review.

In respect of improvements for mental health patients in ED BHRUT and NELFT are working collaboratively to address the issues raised and NELFT have set out a range of actions to improve this situation including improved crisis support into planned care leading to UTC/ED avoidance, improved conveyance diversion from ED and mental health crisis hub working with the police and LAS, improved access to mental health at point of walk in entry to UTC, enhanced mental health presence at ED to improve patient experienced and conveyancing, better data and improved access to senior clinical support when issues arise.

6.4 Provider collaboratives and UEC improvement

UEC improvement is also being supported through two NEL provider collaboratives. The acute provider collaborative has a programme of work looking at improving equity of access to non-elective care for the population of NEL, delivering short term improvement and meeting longer term sustainability requirements. The key workstreams are focussed on ambulance flow (handover and remote emergency

access coordination), front door (UTC's and same day emergency care) and optimising discharge (workforce and urgent diagnostic access)

The mental health, learning disability and autism collaborative is focussed on improving pathways in North East London for people experiencing a mental health crisis, with a particular focus on care received in A&E departments. A portfolio of projects is underway aimed at reducing the need for people to attend A&E, to reduce the length of time people spend in A&E and to improve flow into inpatient services for those requiring an admission.

6.5 In addition to the above BHRUT has established a detailed UEC improvement plan as part of the regular intensive performance framework of system oversight framework level four (SOF4) status. There are monthly progress meetings as part of the SOF4 process, with formal quarterly review meetings with NHSE. A key concern for the CQC was the care and dignity of patients who were waiting in a corridor for access to the Queens Hospital A&E department. In the last fortnight, the Trust has been able to maintain flow, and largely remove the requirement for "corridor care". Further work is required to agree a system-wide response to the CQC requirements and recommendations.

6.6 Actions are monitored through the north east London urgent and emergency care delivery board. A new multi-agency group to focus specifically on improvement across the outer north east London UEC pathway has recently been created, chaired by a clinical leader. This is looking at improvements that can be made across the pathway.

7. Next steps

7.1 The Board is asked to note the next steps and to comment on their adequacy to meet the challenges and issues identified above.

7.1.1 The ICB will carry out a review across the scope of UEC in NE London in order to deliver a System Resilience Plan by early summer building on a review of the 22/23 UEC Winter Plan to be carried out in April 2023

7.1.2 The UEC Programme Delivery Board will develop an overall programme plan for the NEL response to the national UEC recovery plan, co-ordinating with other improvement activities and in light of the NEL System Resilience Plan noted at 5.1 above.

7.1.3 The BHR UEC Improvement Board will deliver the improvement plans for PELC, NELFT and BHRUT, as part of a single plan to improve experience and outcomes in Urgent and Emergency Care, reporting into the three Place Partnerships and through the single NEL Programme Plan for UEC to the UEC Programme Delivery Board

7.1.4 The ICS will continue to assess the implications of the Fuller Review and the national plan for improvement in primary care.

7.1.5 The ICS will continue to implement the Operating Plan for 23/24, taking into account the requirement to demonstrate growth in capacity and productivity

7.1.6 The ICB will set out the process for allocations of additional resources through the Better Care Fund, when national guidance has been disseminated

Clive Walsh
Interim Performance Director
21 March 2023

North East London
Integrated Care Board

NHS North East London ICB Board

29 March 2023

Title of report	Pharmacy, Optometry and Dental Services (PODs) Delegation Programme
Author(s)	William Cunningham-Davis - Director of Primary Care Laura Churchill- Director of the London ICB Network Craig Charlton - Project Lead
Presented by	Jo Moss – Chief Strategy and Transformation Officer
Contact for further information	William Cunningham-Davis - Director of Primary Care Craig Charlton -Project Lead – craig.charlton3@nhs.net
Executive summary	**Paper 1 of 2** - A London wide agreed perspective paper written and shared with each of the 5 ICB Board's in London to gain agreement for the ICB boards. The paper written by the Director of the London ICB Network mainly focuses on the London-wide responsibilities for delegation of POD commissioning services. **Paper 2 of 2** - This paper sets out the specific arrangements for hosting the delegated POD services team within North East London; the internal governance structures, how the teams will interface, both internally and externally with ICB teams and teams at NHSE London, and the arrangements we have in place to manage risks associated with the transfer of staff and responsibility.
Action / recommendation	The Board is asked to: • Approve the establishment of our new operating model and a London-wide oversight group through which the five London ICBs will oversee the work of the newly established POD Hub within NEL ICB. • Note the 'Letter of Comfort' in place with NHS England for the period of 1 April – 30 June while the POD Commissioning Team remains employed by NHSE London Region. • Approve of the memorandum of understanding between NEL ICB and all other ICBs from 1 April. • Approve of the delegation agreement with NHS England and the Scheme of Delegation for NEL ICB to be updated accordingly.
Previous reporting	N/A
Next steps/ onward reporting	Further updates to the Board as this work progresses.
Conflicts of interest	N/A
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money
Impact on local people, health inequalities and sustainability	This paper provides information to the NEL ICB Board on the PODs delegation programme of work as the POD services transition into NEL ICB on 1 April 2023, with a TUPE transfer of staff to follow on 1 July 2023.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report. There is no financial ask.
Risks	This paper includes updates on how risks associated with the transition are being managed.

1.0 The purpose of this document and the ask of the ICB

1.1. London's ICBs have been working closely with the NHSE London Team to prepare for the delegation of POD services. This paper provides a reminder of the national and regional context for this work, and brings together the key elements required for approval and sign off by the ICBs in advance of delegation taking place on 1 April 2023.

1.2. This paper provides a set of recommendations for NEL ICB to ensure that the governance is in place to manage the commissioning functions of POD services in London. These recommendations are:

- **The establishment of our new operating model and a London-wide oversight group** through which the five London ICBs will oversee the work of the newly established POD Hub within NEL ICB.
- **To note the 'Letter of Comfort' in place with NHS England** for the period of 1 April – 30 June while the POD Commissioning Team remains employed by NHSE London Region.
- **The approval of the memorandum of understanding between NEL ICB and all other ICBs** from 1 April.
- **The approval of the delegation agreement with NHS England** and the Scheme of Delegation for NEL ICB to be updated accordingly.

1.3. All of these areas are described in more detail below, and the full documents are available on request.

1.4. Finally, the paper also sets out some of the key risks and their mitigations as we move towards the delegation of POD services and shares some reflections of the collaborative process we have followed to achieve this delegation over the six months.

2.0 Background and context

2.1. The Health and Care Act received Royal Assent on 28 April 2022 and as a result ICBs became legally and operationally established on 1 July 2022. Fulfilling the long-term policy ambition to give systems responsibility for managing local population health needs, tackling inequalities and addressing fragmented pathways of care. A key enabler to realising this ambition is the delegation of direct commissioning functions to ICBs from NHSE.

2.2. From 1 April 2023 NHSE will delegate responsibility to all ICBs for all pharmaceutical, general optometry and dental (primary, secondary and community services (POD). This means that there is an agreement between NHSE and NEL ICB that enables the ICB to take on the responsibility for delivering NHSE functions. The ICB becomes the operational and legal owner of the function, being both responsible and liable for its delivery, with NHSE retaining accountability to Parliament.

2.3. Certain functions will be retained by NHSE such as national contract development and negotiations, performers list management, wider aspects of professional regulation and national transformation programmes.

2.4. Across England more broadly, some ICBs took on the delegation of POD services in the Summer of 2022, however, none were in London. Due to the nature of the single regional POD team working across London to support POD Services Commissioning, London's ICBs have worked together for this delegation and the information in this paper is a result of that collaboration.

Our local context

2.5. In north east London, the delegation agreement relates to a number of contracts and budgetary responsibility. In September 2022 the NEL ICB, along with the other four London ICBs, submitted a pre-delegation assessment framework (PDAF) to NHS England. The framework was developed in collaboration across London and provided an assessment of readiness to receive delegation by each system. This was considered and approved at the NHS England moderation panel on 13 October 2022.

2.6. We have been noting and agreeing to the proposed delegation of the hosted hub model and papers and updates about the formal delegation from NHS England to each ICS nationally on these services from 1 April 2023. The hosting of the Hub team will follow on by 1 July 2023.

2.7. Since then, ICBs across London have worked closely with colleagues in the regional team to prepare for delegation. A series of masterclasses have been run, in areas including the current operating model of the team, quality and clinical oversight, finance and transformation. Most recently we held a masterclass aimed at local government and place-based leaders to share how this delegation may improve local services for patients and citizens in the future.

2.8. London's ICBs and the POD Hub have also constructed a small number of scenarios to allow us to simulate key meetings or 'events' in safe environments. These simulations allowed us to stress-test the documentation we have underpinning the operating model and provide a 'safe' environment in which ICBs and the POD Hub could work through concerns and risks. Documentation has been updated to reflect the learning from these simulations.

3.0 Our operating model for POD Services Commissioning in London

3.1. NHSE London Region currently hosts the POD Services Commissioning Team of 26 people. Within the team, individuals operate across all three of the POD Services and across all areas of London. In the delegation of POD Services Commissioning, the funding for the current establishment, as well as one post from the central finance team, will also be transferred to the ICBs.

3.2. Following two options appraisals conducted in September 2022, the five London ICBs, along with the London Regional Team, agreed a 'Lead Commissioner' operating model, with North East London (NEL) ICB taking this leadership role on behalf of all the London systems. The focus of the detailed design of the operating model and transition plan over the subsequent months has been on achieving a safe-landing of the business as usual aspects of POD services commissioning.

3.3. Following clarification from NHS England, we learned that our ambition to transfer the POD team into NEL ICB "within 12 months" would need to be accelerated to meet a transfer date of 1 July 2023. In summary, the proposed arrangements from 1 April 2023 will be:

- The NHS England commissioning and contracting functions for the POD will transfer to NEL ICB on the 1 April 2023. There will be a delegation agreement between the ICB and NHSE to cover this arrangement (see section 4.14)
- The POD team will remain employed by NHSE from the 1 April 2023 until the 30 June 2023. There a 'letter of comfort' in place between NHSE and NEL ICB for this period to cover roles and responsibilities (see section 4.4)
- The POD team will then transfer over to NEL ICB from the 1 July 2023 as the host organisation, forming a POD Hub. There will be an MOU in place between NEL ICB and the four London ICBs from 1 April onwards (see section 4.6).
- A POD (Delegated Services) Commissioning Oversight Group will be formed across London to provide oversight of the delegation of POD Services at a Pan-London level under the MoU. The terms of reference focuses, in particular, on oversight of the POD Hub's contract management function, the commissioning activity they undertake on behalf of ICBs under the direction of the MoU, and the commissioning advice they provide to ICBs (see section 3.4).

London-wide governance and reporting to underpin the delivery of POD Services Commissioning

3.4. The five London ICBs have worked together to develop the detail behind the operating model. They have drawn up governance and reporting arrangements that mean all ICBs can assure themselves that NEL ICB is appropriately supported and overseen to discharge the commissioning responsibilities on their behalf, through the POD Hub that will be created following the transfer of the POD team. This is important as individual ICBs remain accountable to their populations and to NHSE for these services.

3.5. Terms of Reference for the POD (Delegated Services) Commissioning Oversight Group has been developed (available on request) and scenario testing in February 2023 allowed us to stress-test these terms of reference in a simulated environment. The POD (Delegated Services) Commissioning Oversight Group is accountable to the Integrated Care Board via the Primary care contracts

committee in the ICB.

3.6. The purpose of the POD (Delegated Services) Commissioning Oversight Group will be to provide oversight of the delegated POD Services at a Pan-London level under the agreed Memorandum of Understanding (see section 4.6), focusing, in particular, on oversight of the team's contract management function, the commissioning activity they undertake on behalf of ICBs under the direction of the MoU, and the commissioning advice they provide to ICBs.

3.7. Through participation in the POD (Delegated Services) Commissioning Oversight Group, London's ICBs sign up to a set of principles that will underpin their collective decisions and actions. These are:

- We will adopt a spirit of collaboration and iteration; engaging in decision making by providing constructive feedback with a commitment to making the hosted shared service model work for all parties, and collectively considering POD services commissioning decisions from a London-wide perspective as well as from the perspective of the individual ICB population.
- We commit to enabling the POD Hub to continue to deliver business as usual on a "once for London" basis by addressing POD commissioning decisions through the POD (Delegated Services) Commissioning Oversight Group. We will therefore maintain a coordinated approach across London, whilst exploring where there are opportunities to take actions locally that improve services in line with local population need.
- We will support NEL ICB to make a success of their role as host of the POD services on behalf of London's ICBs.
- We will work to a principle of achieving a break-even position in each ICB in relation to primary care dental contract spend.

3.8. To complement this governance, a set of reporting templates have also been developed and, again, tested through the scenarios in February 2023. ICBs and the POD Team recognise that further refinements and iterations may be required to these reports as ICBs learn more about the information they need.

Local governance and reporting to underpin the delivery of POD Services Commissioning

3.9. NEL ICB has established local governance, connecting to the POD (Delegated Services) Commissioning Oversight Group, to ensure that the ICB is sufficiently informed about the operations of the POD Hub. See separate NEL Specific paper.

The role of NHS England as the employment host prior to a transfer of staff

3.10. NHS England London Region will maintain the employment of staff until 1 July 2023. This has given us time to develop the operating model in advance of the staff transferring over, and means due focus and attention can now be placed on supporting staff through a consultation and transition period, with clarity about what to expect post-transition.

3.11. To ensure the responsibilities are clear for this three-month period, a 'Letter of Comfort' has been drawn up with NHS England London to summarise the roles and responsibilities. This is described in more detail in section 4.4.

4.0 The formal documentation underpinning the delegation of Pharmacy, Optometry and Dental Services (POD) to London's ICBs

4.1. To underpin the delegation of POD services to London's ICBs and to articulate the operating model within which London's ICBs will work, a suite of formal documents requires the approval and sign off from the five ICBs. These are:

- The Memorandum of Understanding between NEL ICB and all other ICBs from 1 April (Annex 1)
- The Delegation Agreement with NHS England, and the subsequent changes required to the ICB's Scheme of Delegation

4.2. The ICB is also asked to note the 'Letter of Comfort' between NEL ICB and NHSE London Region for the period of 1 April – 30 June while the POD Commissioning Team remains employed by NHSE London Region.

4.3. Each document is described in more detail in the sections below, and the full documents are available on request.

The 'Letter of Comfort' between NEL ICB and NHSE London Region

4.4. This letter describes the relationship between NHSE London Region and NEL ICB, while the NHSE London Region continue to employ the POD Team. Under these arrangements London's ICBs are fully responsible for the POD services, and this includes the staff who are delivering this, despite their employer being NHSE. The letter allows NEL ICB to mobilise the POD Hub, and enact the arrangements in place under the MoU NEL ICB has with the remaining London ICBs.

4.5. As such the following elements are of particular importance:

- Agreement that NHSE London will not make changes to the POD Commissioning Team in the three-month period without the agreement of NEL ICB.
- Agreement that NHSE will provide full disclosure of any employer issues associated with the POD Commissioning Team, should they materialise in the three-month period.
- Agreement that NHSE as the employer will direct employees to comply with the reasonable requests of nominated officers of NEL ICB in pursuance of the ICB role as Host of the POD Commissioning function for London and, if necessary, take appropriate action as employer to ensure compliance of the POD Commissioning Team and with relevant individual staff members with any such requests.

The Memorandum of Understanding between NEL ICB and all other ICBs

4.6. The MOU between NEL ICB and the four London ICBs will be locally agreed and will require sign off by the NEL ICB (which is available on request).

4.7. This MoU establishes that the five ICBs have determined that NHS NEL ICB will act as the "Host ICB", hosting the central POD Hub, that will be responsible for co-ordinating the commissioning and contracting of POD services on behalf of all five ICBs.

4.8. The MOU is not intended to be a legally enforceable contract and it does not replace or supersede any legal obligations that will apply to each ICB from 1 April 2023 following delegation of POD services.

4.9. The aim of the MOU is to set out how all five ICBs will work together to:

- provide an initial 'lift and shift' of the POD Commissioning Team to secure a safe landing of the commission function to ICBs.
- share information and commission POD services with a Pan-London perspective.
- discharge their delegated responsibilities effectively.

4.10. The MoU sets out principles for managing commissioning risks, including financial, service delivery, reputational, political and contract performance risks.

4.11. Governance and decision making is reflected in the MoU and this has been described above in section 3.4 with the detailed terms of reference for the POD London-wide Oversight Group.

4.12. Other pertinent highlights of the MoU include:

- Each ICB shall receive its own Financial Allocation for POD Services.
- Income and Expenditure for POD services shall be recorded and managed on the Accounting Ledgers of each individual ICB, and each individual ICB shall be responsible for appropriately reporting such spend against its allocation to NHS England.
- All payments for POD services shall be made directly from the relevant bank accounts of each ICB.
- Each ICB shall be responsible for undertaking any necessary:
    - Accounting Ledger reconciliations.
    - Elements of financial audit associated with transactions on its financial ledger.
    - Adjustments for accruals/prepayments to its own Accounting Ledger.
    - Reporting of spend/income recorded on its own Accounting Ledger.
    - Loading of budgets onto its own Accounting Ledger.

- The budget allocations for each individual ICB shall be based on the expenditure net of income (where applicable) for Financial Year 2022/23 of:
    - General Dental Practitioners located within their geographical boundaries
    - Clinical Pharmacists located within their geographical boundaries
    - General Ophthalmic Service providers with their geographical boundaries
    - For Acute and Community Dental Services, patients registered with that ICB plus a fair share of expenditure relating to patients registered outside of the five ICBs. The fair share shall be based on the ICB's percentage of the total spend for the five London ICBs.
- The POD Hub in NEL ICB shall be responsible for providing any necessary contractual information to support the ICBs in their financial reporting. The POD Hub will also liaise as appropriate with third party payments agencies, responsible for DOPs payments (for example, NHS Business Services Authority and NHS Primary Care Support England (PCSE))
- Decisions regarding the re-distribution of the Financial Allocations for POD Services between the five ICBs, either non-recurrently for a given Financial Year or recurrently, cannot be made by the POD London-wide Oversight Group. Instead, an escalation would be made to NHS England London Region in such a case where re-consideration of the distribution of allocations across London was required.

The Delegation Agreement with NHS England

4.13. The delegation agreement between the NEL ICB and NHS England is a nationally agreed format and wording and will require sign off by the NEL ICB. This document formally outlines the roles and responsibilities of both parties of the delegated functions.

4.14. The Delegation Agreement between NEL ICB and NHS England reflects the following principles:
- Autonomous commissioning – conferring on ICBs the maximum amount of flexibility regarding the use of their delegated functions.
- Consistency between functions – ensuring that the delegation's parameters are as consistent as possible for all delegated functions, and being mindful to avoid setting requirements which would be unhelpful for other NHSE functions which may be delegated in future.
- Building on precedent – aligning the content with all related policy guidance and established national policy frameworks.
- Adaptive to development – with the flexibilities in the Health and Care Act 2022 and given possible outputs from the Hewitt Review, ICBs' system operating models may alter over time. This agreement provides a number of mechanisms – variation, change-via-guidance, and a flexible assurance regime – to respond in a targeted way to changes in ICB maturity and the evolving role of NHSE and systems.

4.15. A thorough check has taken place to ensure alignment between the Delegation Agreement and the MoU between the London ICBs. The following positions will apply across all delegated functions:
- Liability moves to the ICB:
    - The Health and Care Act 2022 locates liability with the body exercising delegated functions (for all functions).
- Onward Delegation:
    - Delegation from an ICB to another (relevant) body is permitted within the agreement, subject to some parameters.
    - Onward delegation to providers (NHS Trusts or Foundation Trusts) or joint committees including providers is not permitted.
    - Onward delegation to joint committees of ICBs is permitted and does not require NHSE approval.
    - Other delegations or joint committees are permitted subject to approval by NHSE.
    - 'Triple delegation' – the further delegation of a function from a body which has delegated functions from the ICB – is prohibited.
    - Internal arrangements – i.e. when an ICB chooses to exercise a function through a place-based subcommittee of the ICB board – does not constitute a form of delegation. This is the case even if external bodies participate in the arrangement.
- Financial Flexibility:
    - ICBs will have the ability to shift monies from the Delegated Budget to their wider budgets (and vice versa), while meeting their contractual obligations, including those through nationally agreed contracts, such as the Community Pharmacy Contractual Framework.

- Duty to comply with Guidance:
    - ICBs now need to comply with a list of specified guidance when exercising the functions. This includes guidance such as the Primary Care policy manuals.
- Planning and Reporting:
    - The ICB is now required to include its plans for exercise of the delegated functions and a report on its performance against these plans in their ICS plan and annual report.
- Assurance:
    - The current approach (which relies almost exclusively on the SOF) is being replaced by a broader and more flexible assurance arrangement. Where appropriate, the agreement has been adapted to refer to any "any applicable assurance frameworks".

5.0 Managing the risks

5.1. Our recommended operating model seeks to manage and mitigate the risks of delegation. Below we provide updates to the pertinent risks raised in the previous papers.

The risks of the transition itself

5.2. Our proposed operating model, first and foremost, seeks to achieve a safe-landing for the POD Team into NEL ICB, and preserve the business as usual commissioning activity for London's ICBs. We are actively managing and mitigating the following risks:

- **Lack of information pertaining to the contractual and commissioning arrangements leading to the ICBs not fully understanding the functions that they are taking on.**
  This risk has been partly mitigated through the roll out of a series of masterclasses for ICBs, working groups to develop the operating model and continues to be mitigated through due diligence. Using the safe delegation checklist, and working with the leads within each ICB to ensure that there are robust arrangements in place, with all parties, to ensure the safe discharge of the delegated functions.

- **Lack of understanding of the requirements on ICBs to enact their role as commissioners of POD services, leading to ICBs being unable to plan for the necessary resourcing.**
  This risk has been mitigated through the series of masterclasses, the working groups to develop the operating model and the scenario testing that has allowed us to stress-test our arrangements. NHS England also confirmed the transition of the full allocation of resource from the existing POD Team into the ICBs, and as we developed our operating model we built in an additional finance post to ensure the ICB Finance teams are supported in taking on these new responsibilities.

- **Disruption over the transition period risks the retention of the experts within the POD Team. This expertise is in scarce supply, and so the loss of key people could put the delivery of the POD Services Commissioning at risk.**
  This risk is being mitigated through a close working relationship with the Head of the POD Team, who sits on the Steering Group, so that information can quickly and easily be passed back to the POD team. The conclusion of the options appraisals has led to more clarity for the POD Team themselves.

Risks from day one, following a "safe landing"

5.3. The following themes make up the risks from day one, following a "safe landing":

- **Inefficient or misaligned governance and decision making, or a lack of clarity around roles and responsibilities, leading to delays and non-value adding pressure on system capacity.**
  The MoUs between the ICBs, and the ICBs and NHSE London Region, has been key to establishing robust governance and decision-making arrangements. A series of simulations has helped to identify scenarios where the governance is not working as well as it could so this can be rectified before delegation takes place.

- **ICBs have not developed a sufficient understanding of the required resources to oversee the commissioning of POD services, and so are unable to effectively and efficiently support the POD team, or future ambitions for transformation.**
  This risk has been managed partly through the transition of the POD Team, as is, and the focus on achieving a safe landing such that they can continue their business as usual activity. This risk is being further managed by the regular attendance of the NEL team at all London-wide steering group meetings which enables the HUB team via the PCCC to respond in a timely way to required actions.

- **The transition itself, or the future transfer, severs links with key infrastructure for the POD team, such as the complaints function, clinical networks or public health consultants.**
  The development of the MoU between the London ICBs and the NHSE London Region articulates the necessary infrastructure for the POD Team, and how this will continue to be provided after 1 April.

6.0 Learning from our collaboration on the delegation of POD services

6.1. The delegation of POD services marks the first time that London's ICBs have come together in a collaborative effort to achieve the delegation of a service from NHS England. This has been a positive learning experience and has demonstrated that London's ICBs are able to work effectively and coherently together to achieve a common goal.

6.2. The ICB Leads for the delegation of POD Services created a senior steering group through which they developed a common operating model and utilised a series of coordinated working groups of experts to refine and agree the details. They also reported and engaged effectively with senior colleagues within the broader ICS ensuring buy-in, support and a means for feedback as the operating model developed.

6.3. At least three other services (Specialised Commissioning, Primary Care Complaints and Section 7A) will be delegated to ICBs in the coming months, and so it is important to reflect on what we have learned from this delegation to support and improve future programmes.

6.4. Below are some of the key reflections from the Programme Team:

- There is a need for dedicated programme management capacity and leadership in both NHSE and across the ICBs – this is a complex process involving a wide range of stakeholders and there is a need to ensure that decisions are made, communications are clear, and timelines are met throughout the processes.
- There are clear phases, processes, and deliverables for the delegation process that will be common to all programmes, creating the opportunity for consistency in the way we approach them.
- The programme may be required to adapt quickly - there are likely to be significant changes to policy and process as it progresses (national policy changes, time required for ICBs to gather information required to make informed decisions, etc), as a result, running the programme using an 'Agile' approach has been successful.
- A wide range of subject matter experts, functional and clinical leads will be required to input into the process (the service leads plus reps from workforce, finance, comms, contracting, etc); this will require PMO coordination and clear governance / workstream structures.
- Significant knowledge transfer needs to take place between NHSE and ICBs; this needs to be organised and facilitated (via Masterclasses, Demos to enable knowledge sharing, etc).
- Delegation requires the development of a wide range of different documentation, much of which can be drawn in for subsequent programmes (e.g., MoUs, Scenario Planning, Options Appraisal, EQIAs).

6.5. A more comprehensive After-Action Review is planned for April so that more detailed feedback can be gathered across the wide range of stakeholders who have participated in this work.

North East London
Integrated Care Board

NHS North East London ICB Board

29 March 2023

Title of report	Pharmacy, Optometry and Dental Services (PODs) Delegation Programme – a NEL focus as the host.
Author(s)	William Cunningham-Davis - Director of Primary Care Laura Churchill- Director of the London ICB Network Craig Charlton - Project Lead
Presented by	Jo Moss – Chief Strategy and Transformation Officer
Contact for further information	William Cunningham-Davis - Director of Primary Care Craig Charlton -Project Lead – craig.charlton3@nhs.net
Executive summary	**Paper 2 of 2** - In addition to the paper written and shared with the ICB Board from the Director of the London ICB Network which focuses on the London-wide responsibilities for delegation of POD commissioning services, this paper sets out the specific arrangements for hosting the delegated POD services team within North East London; the internal governance structures, how the teams will interface, both internally and externally with ICB teams and teams at NHSE London, and the arrangements we have in place to manage risks associated with the transfer of staff and responsibility.
Action / recommendation	The Board is asked to note the update.
Previous reporting	N/A
Next steps/ onward reporting	Further updates will be brought to the Board as this work progresses.
Conflicts of interest	N/A
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money
Impact on local people, health inequalities and sustainability	This paper provides information to the NEL ICB Board on the PODs delegation programme of work as the POD services transition into NEL ICB on 1 April 2023, with a TUPE transfer of staff to follow on 1 July 2023.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report. There is no financial ask.
Risks	This paper includes updates on how risks associated with the transition are being managed.

1.0 Context

1.1. The March NEL ICB Board meeting papers include a briefing paper written for the five London ICBs, which summarises the joint work completed to date at the London level to ensure a smooth transition of delegated Pharmacy, Optometry and Dental services from NSH England London Region to the five London ICBs. The focus of this work and the design of the operating model and transition plan over the past few months has been on achieving a safe landing of the business-as-usual aspects of POD services commissioning.

1.2. The briefing paper above also includes the full and final text of the governance documents (a Memorandum of Understanding between partners and information about the national delegation agreement) that will need to be agreed in March 2023 by London Integrated Care Boards.

1.3. Whilst the five London ICBs will need to sign the MoU and continue to prepare to engage with the delegated POD commissioning team, NEL ICB has additional responsibilities as the host and future employer of the delegated POD commissioning team. This paper sets out additional detail about the programme that has been taking place to ensure a smooth landing for the team and to assure the Board that NEL ICB is effectively managing this transfer, including work to mitigate or minimise associated risks.

2.0 The NEL Perspective

2.1. As part of the London-wide work referred to in the other briefing paper, a team from NEL ICB has been working with partners to develop the various governance documents and future London-wide ways of working with regard to the commissioning activities that will be carried out by the hosted team at NEL ICB, and the services they will provide on behalf of London ICBs.

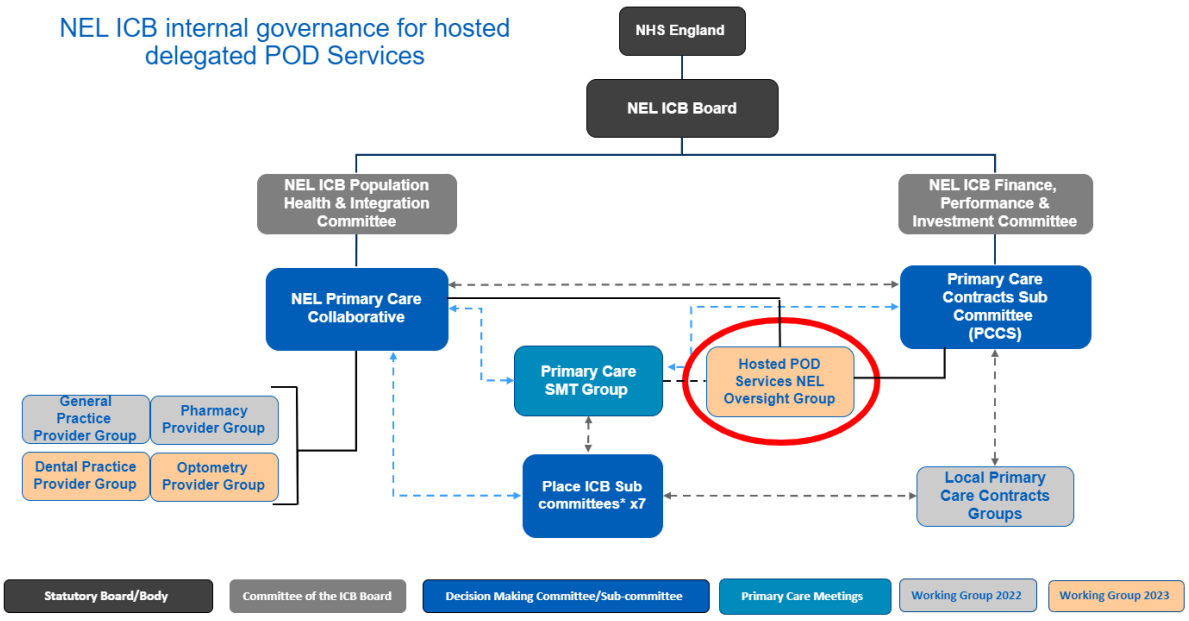
2.2. Within NEL ICB a weekly Task and Finish Group has been preparing for delegation, with a few key workstreams covering areas of responsibility. The rest of this paper updates on these:

- Governance and management of risk
- TUPE transfer of staff and people considerations
- HR
- IT
- Services
- Finance

3.0 Governance and management of risk

3.1. Management responsibility for the delegated POD services commissioning team at NEL ICB sits with the Managing Director (MD) of Primary Care, within the portfolio of the Chief Strategy and Transformation Officer.

3.2. Within NEL ICB, once the transition is complete and delegation has taken place the hosted POD Services will be managed by the Primary Care SMT group, with oversight provided by a NEL Oversight Group which reports into both the Primary Care Contracts Subcommittee and the NEL Primary Care Collaborative:



3.3. The POD Services NEL Oversight Group will have ongoing responsibility for escalating any significant risks associated with delegated POD services commissioning, from the perspective of NEL ICB as host, within the ICB.

3.4. Most of the work of the hosted POD services commissioning team will be governed by the London-wide MoU and for this reason we have carried out a number of activities to assure ourselves of the robustness of the MoU in limiting any liability or risk from unnecessarily falling to NEL ICB.

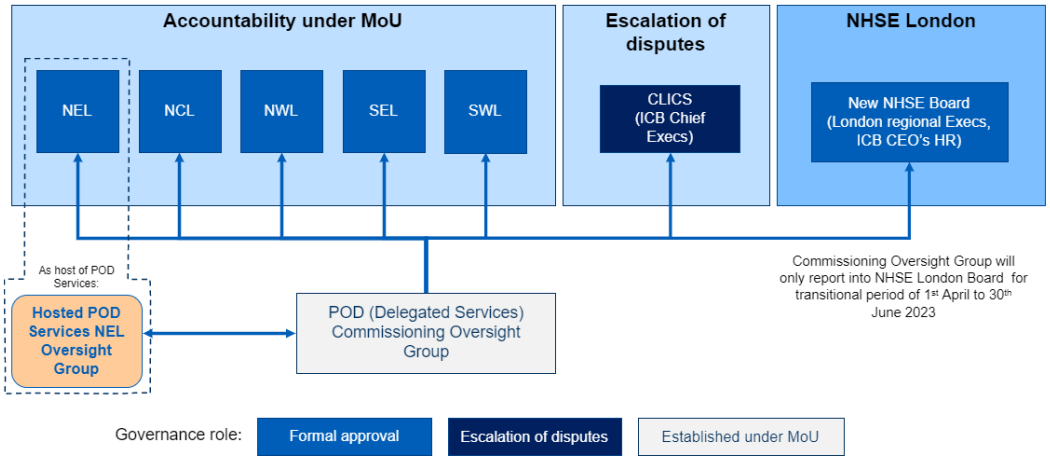
3.5. This has included:

- Having our legal counsel review the MoU and provide feedback on it – we have had this feedback and we are working through the some of the advice we've received, however we received no feedback that required material changes or which would give rise to any delay in proceeding.
- We have engaged our auditors to carry out a review of the proposals – we have received a specification from them and this will be carried out during the next phase of transition as we prepare for the transfer of staff on 1 July.

3.6. During the day-to-day activities of the delegated POD commissioning team, there will be specific points at which the team interfaces with functions in different ICBs and in NEL ICB – as part of our preparations for transition the NEL ICB Task and Finish group have worked with the PODs team to update and document all of their key business processes or standard operating procedures to make clear when the team will operate with delegated authority on behalf of other ICBs, and when the team will contact ICB teams to request a decision from an ICB based on a standard function that the team supports. This work is being shared with other ICBs via the London wide groups.

3.7. The MoU which governs the service provided by the hosted POD services team to each London ICB (including NEL ICB) sets out a regular meeting at London Level which will manage how the partners to the MOU agree on collective decisions and how the team will report to partner ICBs on commissioning activity carried out on their behalf NEL ICB will be responsible for convening this POD (Delegated Services) Commissioning Oversight Group:

London-wide future proposed governance for PODs Delegation



3.8. Terms of Reference for the POD (Delegated Services) Commissioning Oversight Group (POD COG) have been developed (available on request) and scenario testing in February 2023 allowed us to stress-test the terms of reference in a simulated environment. The POD (Delegated Services) Commissioning Oversight Group is accountable to the five London Integrated Care Boards.

3.9. Should the London ICBs fail to agree on any collective decisions in relation to the ongoing management or operation of the delegated POD services at the Commissioning Oversight Group an escalation route has been agreed via the CLICS meeting of ICB London Chief Execs.

3.10. NEL ICB has worked closely with colleagues in the regional team to prepare for delegation. A series of masterclasses have been run, in areas including the current operating model of the team, quality and clinical oversight, finance and transformation. (further details of the outcomes of the masterclasses, available on request)

4.0 TUPE transfer of staff to NEL ICB and people considerations

4.1. From 1 April, under the national delegation agreement, London ICBs will take on delegated responsibility for POD services and the London ICBs will sign the MoU agreeing for the existing POD services team to be hosted by NEL ICB and operate on a hub model on behalf of all five London ICBs.

4.2. However, despite the London ICBs holding delegated responsibility for POD services and budgets, the transfer of staff from NHSE to NEL ICB will not take place at the same time as the national delegation of responsibility for POD services, with the full transfer of staff set to complete on July 1st, 2023, following due diligence and HR processes.

4.3. To manage the risks associated with this period, the five ICBs have requested a 'Letter of Comfort" from NHS England as employer of the Hub team, (available on request) which has been agreed to and drafted, and which provides the following assurances:

- Confirmation that NHSE will not make changes to the POD Commissioning Team in the 3-month period without the agreement of NEL ICB;
- That NHSE will provide full disclosure of any employer issues associated with the POD Commissioning Team, should they materialize in the 3-month period;
- That NHSE as employer will direct employees to comply with the reasonable requests of nominated officers of NEL ICB in pursuance of the ICB role as Host of the POD Commissioning function for London, and if necessary, take appropriate action as employer to ensure compliance of the POD Commissioning Team and, where relevant, individual staff members, with any such requests. The staff consultation on the transfer of the POD services commissioning team to NEL ICB is being led by NHS England London Region as the 'sending' organisation, with colleagues in NEL ICB's People directorate fully engaged with the process as the 'receiving' organisation.

4.4. From April we will move to the next phase of our preparatory work and our focus as a programme will be on supporting the people aspects of the transfer. We have had legal advice from HR that under the TUPE / COSOP guidance, transferring staff will be protected for a minimum of 12 months from inclusion in London ICB restructures associated with making efficiency savings through reductions in establishment costs.

5.0 Next Steps and Recommendations

5.1. The NEL ICB Board are asked to note the process and progress to date.

North East London
Integrated Care Board

Integrated Care Board

29 March 2023

Title of report	Joint working model with NHSE for Specialised Services for 2023/2024
Author	Archna Mathur, Director of Specialised Services and Cancer
Presented by	Dr Paul Gilluley and Archna Mathur
Contact for further information	Archnamathur@nhs.net
Executive summary	On 2 February at its Board meeting, NHS England approved plans to commission jointly with Integrated Care Boards, 59 service areas (some but not all specialised services) from April 2023. Following discussion between ICB Chief Executives and NHSE London through the existing Partnership Board it was agreed that London will have a single joint committee; this will allow for co-ordinated decision making between ICBs and NHSE during this transitional year. An overview of the Joint Working Agreement is attached, the full document of which has been shared with ICBs for comment. This report was discussed at the Finance, Performance and Investment Committee on 27 February to ensure the ICB had early oversight of the process, proposals and therefore able to put forward a recommendation of approval to the Board for ICS CEO signature.
Action required	The Board is asked to approve the Joint Working Agreement and joint working arrangements for the commissioning of specialised services in 2023/2024, thus authorising the ICB Chief Executive to sign the document on behalf of North East London ICB enabling new commissioning arrangements for specialised services to 'go live' from April 2023.
Previous reporting	ICB Chief Executives, NHSE London through the existing Partnership Board and ICB Finance, Performance and Investment Committee.
Next steps/ onward reporting	ICB Chief Executive to sign the Joint Working Agreement on behalf of the ICB.
Conflicts of interest	There are no conflicts of interest arising in this report.
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	Specialised services are a diverse portfolio of c150 services generally accessed by people living with rare or complex conditions. These include services for people with physical health needs, such as cancer, neurological, and genetic conditions and some mental health services too. Within NEL, the APC (Acute Provider Collaborative) will deliver the specialised service programme on behalf of the ICB, optimising the expertise of specialist clinicians and teams to drive economies of scale across NEL, improve care for local populations and working in a matrix on end to end pathway redesign with “place” to improve LTC management and prevention, aiming to reduce the future financial risk and demand on specialised services. The Joint Working Agreement is a stepping stone to full delegation that ensures the ICB and Trusts are closer to designing and shaping specialised services, bringing together clinicians, operational teams and clinical networks to redesign services to meet local population needs. The clinical priority areas of focus for 23/24 in NEL are Renal care, Haemoglobinopathies (sickle cell), specialist paediatrics, neurosciences, HIV opt out testing and liver disease. These priority areas are based on population need and requirement to reduce existing clinical inequality in our population.
Impact on finance, performance and quality	Funding for specialised services will shift from historic population-based allocation towards needs-based allocation, CFOs across London are proactively working with regional and national colleagues to clarify how the change in practice will work and also refine the methodology to understand the potential funding gap within each ICS at the point of delegation. The delegated budget from April 24 is c£597m and this is set to increase year on year as NHSE deems more services suitable for delegation. Additionally, our population is set to grow by 364k over the next 20 years, which puts pressure on specialised services, but also non-specialised services which patients may step down into e.g. level 1 specialised neuro-rehabilitation patients may eventually access community rehabilitation programmes as part of their longer-term treatment plan
Risks	• Implications of shift to needs based allocation. As part of the move to ICSs leading specialised services, NHSE plans to transition to providing funding to ICBs for specialised services. This will initially use historic spend information that supports host-based allocations but over time, this will transition towards an allocation based on a population needs-based formula, bringing these services more into line with other funding streams. NHSE expects to implement a 'needs-

	based' allocation model in a phased way from 2024/25, with 'pace of convergence' safeguards to ensure systems do not see destabilising changes in funding levels. • Resources to deliver the specialised service delegation programme are a key risk as the delegation is not accompanied by NHSE resource. This is because the management of a significant number of highly specialised service lines will be retained by NHS England. Resource mitigations are however in place with a resource plan submitted to the ICB for consideration alongside the forthcoming staff consultation for which approval is pending.

1.0 Background

1.1. On 2 February at its Board meeting, NHS England approved plans to commission jointly with Integrated Care Boards, 59 service areas (some but not all specialised services) from April 2023.

1.2. It is anticipated that jointly commissioning specialised services where appropriate will enable the delivery of more joined-up care for patients, improving their experiences and outcomes from treatment. Integrated commissioning supports a focus on population health management across whole pathways of care, ultimately aimed at improving the quality of services, tackling health inequalities and ensuring best value.

1.3. From 1 April 2023 NHS England and multi-ICB collaborations - covering nine geographical footprints – will establish statutory joint committees that will oversee and take commissioning decisions on 59 specialised services. This will coincide with the introduction of population-based budgets for these services from April 2023.

1.4. Commissioning responsibility for all other specialised services will be retained by NHS England - for some services, this will be on a permanent basis and for others this will be temporarily until they are considered ready for delegation.

1.5. These plans, which were first set out in the Roadmap for Integrating Specialised Services within Integrated Care Systems, have been developed in close collaboration with NHS England's regional teams, ICBs and specialised service providers. They represent the outcome of a thorough assessment of ICB system readiness, and a comprehensive analysis of services to determine their suitability and readiness for more integrated commissioning.

1.6. The arrangements in 2023/2024 represent a stepping-stone to delegating full commissioning responsibility for suitable services from April 2024. This will be subject to further Board consideration and decision.

2.0 The Joint Working Agreement

2.1. The Joint Working Agreement has been developed to legally underpin the joint working model in 2023/2024 for statutory joint committees between multi-ICBs and NHS England for the 59 services that are appropriate for more integrated commissioning. These arrangements will be implemented using NHS England's powers under section 65Z5 of the NHS Act 2006.

2.2. This model will support the transition to fully delegated commissioning arrangements for appropriate services in future years.

2.3. The joint working model will be implemented to 'go live' from April 2023 and will:

a) Introduce joint decision-making between NHS England and ICBs for specialised services that are suitable and ready for greater ICB involvement.
b) Require the establishment of a joint committee of NHS England and ICBs to facilitate collaboration and decision-making in relation to the services.
c) Confirm that, to support a managed transition towards full delegation, for 2023/2024 finances, liability and contracting will remain with NHS England, albeit overseen by the joint committee.
d) Confirm that commissioning teams will remain within NHS England in 2023/24 to support the transitional arrangements.
e) Provide decision-making safeguards for NHS England, recognising that this is a transitional year and liability remains with NHS England.
f) Allow the committees to be consulted on specialised services that are being retained by NHS England, although they will not have any decision-making powers relating to these services. In accordance with the NHS England Scheme of Delegation, the decisions to introduce arrangements under section 65Z5 and 65Z6 of the NHS Act 2006 are matters reserved to the NHS England Board.

2.4. The joint working agreement is a national document, ensuring consistency across England. There are areas for local flexibility. The approach in London to these is set out below.

3.0 London Arrangements

3.1. Following discussion between ICB Chief Executives and NHSE London through the existing Partnership Board it was agreed that London will have a single joint committee; this will allow for co-ordinated decision making between ICBs and NHSE during this transitional year.

3.2. The South London and North London ICBs will continue to meet as South/ North London Programme Boards, reporting into the Joint Committee; this will establish an appropriate geographic footprint for planning multi-ICB services (i.e., paediatrics, neurosurgery, cardiac, specialist respiratory etc), particularly taking account of significant patient flows from other regions.

3.3. A JWA+ (known as the Pathfinder Programme) has been established in South London; progress reports will be made to the joint committee ensuring that all ICBs in London learn from these developments in a consistent way and can participate in them as appropriate.

3.4. The London Joint Committee creates a decision-making forum for:

- London wide issues e.g., cancer, neo-natal transport, resilience.
- Pan ICB quality issues, should they arise.
- The impacts of and any changes to patient flows from other regions.
- Developing a regional approach to nationally retained services and services identified as suitable but not yet ready for delegation to ICBs.

4.0 Amending the joint working agreement for London

4.1. The Joint Working agreement has been amended for London following discussion at the London Partnership Board and following discussion with Specialised Commissioning ICB Leads and ICB Governance leads. As a national document used by all 7 regions, there are

only a few schedules and clauses open for local amendment. The areas which were updated include:

a) **Schedule 2** – the template Joint Committee Terms of Reference for regions and ICBs to adapt. For London the key changes include:
    - A description of accountability and oversight reporting to the London Regional Executive as a means of ensuring appropriate levels of scrutiny.
    - Decision-making where consensus is not reached by the membership of the Joint Committee. The London Partnership board agreed that there will be equal voting rights with NHS England holding a casting vote. Each ICB has a single vote and NHS England has a number of votes equal to the number of ICB votes. Where there is deadlock, NHS England has a casting vote at the meeting of the Joint Committee.
    - A description of the roles and responsibilities of the membership including the London approach to clinical representation. ICBs have agreed representation at Chief Executive level. A provider representative from North and South London has been included, and two ICB Chief Financial Officers representing North and South London. It has also been agreed to offer ICB chief medical officers (CMOs), chief nursing officers (CNOs) and allied health professional leads (AHPs) each a place on the Joint Committee, should they wish to take this up. CMOs, CNOs and AHPs have been written to, to ask if they collectively wish to take up this place, who they would like to nominate and through what mechanism would the nominee keep their colleagues informed of what is discussed at the Joint Committee (each is expected to represent their professional area on behalf of all 5 ICBs in the meetings).

b) **Schedule 9 – local terms** - A schedule for local partners to adapt to detail additional governance arrangements including sub-committees. For London the key changes include:
    - An organogram showing the regional governance meetings that support the Joint Committee
    - A description of the Joint committee subgroups; The “Finance Advisory Group”, The “Delegation, Planning & Commissioning Committee” and the “Integrated Specialised Quality & Patient Safety Committee”
    - A description of the extended specialised services governance for North and South London including the description of the “North London Programme Board for Specialised Services”, the “South London Specialised Executive Management Services Board” and the “South London Pathfinder Programme”

5.0 Ways of working

5.1. In London it was also decided that a number of principles in terms of ‘ways of working’ needed to be adopted. Specifically:

1. NHSE and ICBs will work in a transparent collaborative way as co-commissioners of specialised services. The Joint Committee will not be used as a forum to performance manage ICBs, as this would confuse NHSE’s regulatory role with that of its commissioner function.
2. Where there are breaches of the agreement by either NHSE or the ICBs, Partners can raise their concerns either individually or collectively through the Joint Committee.

6.0 Recommendation

6.1. To ensure the agreements are in place for 1st April 2023, ICB Boards are being asked to authorise ICB Chief Executives to sign the Joint Working Agreements with NHSE.

6.2. **The Board is asked to:** approve the joint working model for the commissioning of specialised services in 2023/2024 to enable the ICB Chief Executive to sign the Joint Working Agreements on behalf of North East London ICB to enable new commissioning arrangements to ‘go live’ from April 2023.

North East London
Integrated Care Board

NHS North East London ICB Board

29 March 2023

Title of report	Month 10 2022-23 Finance and Performance overview
Author	Julia Summers
Presented by	Henry Black, Chief Finance and Performance Officer
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Executive summary	**Key Items** • The report outlines the year-to-date financial position for the ICS and the ICB. The ICB and CCG budgeted allocation to the end of January was £3,424m. • The ICS have reported an unfavourable system variance to plan at month 10 of £44.2m, primarily due to inflationary pressures and slower than planned delivery of system savings and cost improvements. • Within the ICS year to date position, the ICB has reported a month 10 year-to-date overspend of £1m. • As reported in previous months, the ICB and system partners have been in discussion with regulators about a movement from a break-even position to a year-end deficit position. It has been agreed that the year-end system deficit will be £35m (£34m provider deficit and £1m ICB deficit). If this position is achieved, it will result in NHSE releasing £10.5m resource, resulting in a final year-end deficit of £24.5m. It is expected that this resource will be received in month 12 but it is assumed as an income source in the month 10 position. • The ICB Chief Finance and Performance Officer (CFPO) has constituted a finance recovery working group across the whole of the ICS. This group will review and drive forward the in-year financial position, efficiency and savings targets and oversee the development of a 5 year system financial plan. • With regards to the in-year position, current liabilities have reduced by a net £73m since 31 March 2022. The main drivers of this has been the clearance of 2021/22 invoices (paid in 2022/23) and the release of non NHS accruals into the financial position. These payments and release of accruals to fund other cash items has resulted in a total cash requirement of £109m in excess of the estimated cash drawdown limit for the year. All contractual payment

	obligations for 2022/23 are expected to be made prior to 31 March 2023. • Work is currently is underway to develop a 23/24 finance plan. This has shown that the start point for the ICB is a circa £79m underlying deficit. Further updates on the plan will be presented to future committees. • Alongside the planning round the contracting round is underway for 23/24. NHSE require that ICBs and providers have fully signed contracts. The contracting guidance has changed significantly with a return to cost and volume contracts with acute providers for elective services. It is expected that contracts will reflect agreed targets and financial allocations. The contracts will need to be signed by both the ICB and providers. • The performance update presents an analysis of key system operational performance indicators against national and locally agreed targets relating to acute, mental health, community and primary care services. The data is mostly based on Month 8 (November 2022).
Action required	• Note the content of the report and the risks to the financial position. • Note the performance update and the key risks of delivery. • Recommend for approval the delegation of authority for the signing of contracts and contract variations to the Chief Finance and Performance Officer and one other chief officer. This is to ensure contracts are signed within the required timescales.
Previous reporting	N/A
Next steps/ onward reporting	Future financial and risk updates will be given to the ICB Board, ICB Finance, Performance and Investment Committee and the ICB Audit and Risk Committee.
Conflicts of interest	No conflicts of interest
Strategic fit	NEL wide plans are set on the financial resources available. The report provides an update of financial performance against the plan.
Impact on local people, health inequalities and sustainability	Update of financial sustainability and performance of the system. Specific performance indicators address performance against the needs of those with protected characteristics (as defined by the Equalities Act) such as disability and that is included in the report.
Impact on finance, performance and quality	Delivery of the financial plan and meeting the control total and delivery of performance metrics and constitutional standards are mandated requirements.

Risks	Key risks have been identified as inflation, efficiencies and ICB run rate pressures within CHC and prescribing. Further system risk has been identified in relation to workforce and pay pressures with partners and system wide investment programmes. Key performance risks are highlighted in the paper and have been identified in planned care, outpatient transformation, diagnostics, cancer, urgent and emergency care (UEC) and mental health.

ICB Board – Finance and Performance Overview

1. Purpose of the Report

The month 10 finance report provides the ICB Board with an update on the year-to-date and forecast financial position of both ICB and NEL system. It describes the drivers of spend and risks to the reported position. The ICB Board is asked to note the movement to a forecast year-end deficit across the NEL system. The detailed financial performance is attached in Appendix 1.

The month 8 performance update provides the ICB Board with the latest published performance position and the risks associated with delivery. The performance dashboard is attached in Appendix 2.

The report provides an overview of the 23/24 contracting round.

The ICB Board is asked to note the information in the finance and performance overviews.

The ICB Board is recommended to approve the delegation of authority for the signing of contracts to the Chief Finance and Performance Officer and one other chief officer.

2. Month 10 Finance Overview

The month 10 year-to-date position across the NEL system is a overspend variance to plan of £44.2m. This is made up of a provider overspend variance of £43.2m with an ICB overspend variance of £1m.

The reported year-to-date variance is summarised by statutory organisation in the table below.

Organisations	Year to date			Forecast Outturn		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
BHRUT	(0.9)	(21.3)	(20.5)	0.0	(14.6)	(14.6)
Barts Health	0.0	(20.3)	(20.3)	0.0	(12.9)	(12.9)
East London NHSFT	(0.5)	(0.1)	0.4	0.0	3.0	3.0
Homerton	(0.1)	(2.8)	(2.6)	0.0	0.0	0.0
NELFT	0.0	(0.2)	(0.2)	0.0	(0.0)	(0.0)
Total NEL Providers	**(1.5)**	**(44.7)**	**(43.2)**	**0.0**	**(24.5)**	**(24.5)**
NEL ICB	0.0	(1.0)	(1.0)	(0.0)	0.0	0.0
NEL System Total	**(1.5)**	**(45.7)**	**(44.2)**	**0.0**	**(24.5)**	**(24.5)**

The ICB has moved from a year-to-date reported underspend in month 9 (£18.5m) to a reported year-to-date overspend of £1m in month 10. This is partly as a result of the treatment of the elective recovery fund (ERF). In previous months it was expected that there would be an ERF clawback from providers. This was treated as an underspend in the ICB's reported position, with a corresponding overspend in the provider position. In month 10 it is assumed that there will be no clawback of ERF and as a result the treatment of ERF in previous reporting periods has been reversed.

The majority of the year-to-date pressures are shown against BHRUT and Barts, with a smaller year-to-date pressure at the Homerton. The reduction in the provider year-to-date pressure is in part due to the reversal of the ERF treatment.

Following on from discussions between the ICB, system partners and the regulators there has been a movement from a forecast break-even position to a forecast deficit position. The agreed forecast deficit for the NEL system is £35m. Achievement of this position at year-end will result in NHSE releasing additional resource to the system of £10.5m. This will offset part of the £35m deficit resulting in a final year-end deficit of £24.5m. It is expected that this resource will be received in month 12 but it is assumed as an income source in the month 10 reported position.

The table above shows the split of the final expected forecast by provider and the ICB. It is expected that by year-end the ICB, Homerton and NELFT will break-even and that there will be overspends at Barts and BHRUT. ELFT is reporting a year-end surplus of £3m as a result of non-recurrent benefits being released into their 2022/23 position.

The key pressures remaining at a system level are as follows;

- **Inflation** – providers have reported additional costs in relation to inflation being higher than planned levels.
- **Provider Payroll costs** – providers have reported pressures in relation to staff pay, including agency staffing. Average total monthly pay across all providers is £237m and is on an upward trajectory compared to the same period last year. The overall payroll costs across all providers remains fairly static between months 9 and 10.
- **Agency spend** – providers have flagged payroll pressure, specifically in relation to spend on agency staff. The total amount forecast to be spent is £191m which is an increase from month 9. Extrapolation of current rates indicates that the year-end position without mitigation would be in the range of £195m to £205m. A forecast in this range would cause the ICS to breach the agency cap imposed as part of the operating plan.
- **Efficiency and cost improvement plans** - the total system efficiency and cost improvement plan at month 10 is £151m. Providers and the ICB have assessed

performance against this target and are reporting slippage against the plan of £33.5m. These plans included an overall reduction in payroll costs have not been seen across the system. Of the efficiency and cost improvement plans delivered, the system is falling short in delivering the benefits recurrently. This means that efficiency and cost improvements remain an outstanding risk for the delivery of in year financial balance and the recurrent impact into financial year 2023/24.By the end of the financial year there is expected that the system shortfall in the forecast position is expected to be £35.7m.

2.1.1 - ICB year to date position

A level of efficiencies was built into the ICB budgets in the planning cycle. However, there is still an unidentified efficiency target which has led to a year-to-date pressure of £28.2m at month 10. The ICB has a continued run rate pressure in CHC of £6.7m relating to high cost package and observation costs and a run rate pressure in primary care and prescribing of £6.7m (5% overspend on prescribing budget). The prescribing pressure has been driven by activity and price increases, with price concession increases a significant risk to the year-end forecast. Part of these pressures are offset by other ICB budgets, with the remainder offset by non-recurrent balance sheet mitigations.

Within the ICB reported position, there are costs relating to the additional hospital discharge funding that the government made available to health and social care to increase capacity in post discharge care. This is shown as an overspend in the ICB reported position with a retrospective claim to NHSE to reimburse the costs incurred.

This is shown in the table below.

Month 10	YTD Variance £m
ICB Run Rate Pressures	
Operating plan budgetary pressure	(28.2)
Community Health	(1.2)
Continuing Care	(6.7)
Primary Care - Delegated	0.0
Primary Care - Other	(6.7)
Programme Corporate	(1.7)
Other Areas	9.0
Total Pressure	**(35.5)**
Mitigation	
Gap Mitigation - Balance Sheet	33.0
Gap Mitigation - S256	0.0
Gap Mitigation - Other	0.3
Total Mitigation	**33.3**
Month 10 Position	**(2.2)**
Hospital Discharge Reimbursement	1.2
Month 10 Revised Position	**(1.0)**

2.1.2 - 2022/23 Forecast

Following on from discussions with the regulators the expected forecast position for the NEL system is a year-end deficit of £35m. If this is achieved it will be partly offset by an additional resource from NHSE of £10.5m resulting in a final expected year-end deficit of £24.5m.

2.1.3 - ICB Forecast position

The ICB has a number of underlying run rate pressures, however at month 10 it is expected that these will be mitigated and the ICB will report a forecast breakeven. This is highlighted in the table below.

Month 10	FOT Variance £m
ICB Run Rate Pressures	
Operating plan budgetary pressure	(36.3)
Community Health	(8.3)
Continuing Care	(7.5)
Primary Care - Delegated	0.0
Primary Care - Other	(7.4)
Programme Corporate	(5.4)
Other Areas	2.4
Total Pressure	**(62.4)**
Mitigation	
Gap Mitigation - Balance Sheet	50.9
Gap Mitigation - S256	4.4
Total Mitigation	**55.3**
Month 10 Position	**(7.1)**
Hospital Discharge Reimbursement	7.2
Month 10 Revised Position	**0.0**

To enable this position to be achieved the ICB is expecting to deliver a number of non-recurrent mitigating actions, such as the release of accruals from the balance sheet.

With regards to the in-year position, current liabilities have reduced by a net £73m since 31 March 2022. The main drivers of this has been the clearance of 2021/22 invoices (paid in 2022/23) and the release of non NHS accruals into the financial position. These payments and release of accruals to fund other cash items has resulted in a total cash requirement of £109m in excess of the estimated cash.

Delivery of mitigating actions has been challenging and due to the non-recurrent nature of some of the balance sheet releases, will impact on the underlying starting position of the ICBs 2023/24 financial plan. Work is underway to submit a draft financial plan to NHSE but work on this suggests that the underlying starting deficit of the ICB is a deficit of circa £79m. Updates on the plan will be given at future committees.

Work is ongoing to continue to review and deliver efficiency opportunities, working with system wide partners to drive a sustainable financial position across the ICS, reviewing the delivery, profiling and impact of all investments, and analysing non-recurrent opportunities including a review of all balance sheet items and provisions. To date approximately £55.3m of non-recurrent mitigations have been identified.

2.1.4 - Risks and mitigations

As outlined above the ICB and ICS are facing year-to-date financial pressures but have reported a forecast outturn to plan position. Mitigations have been identified for the ICB and Homerton, ELFT and NELFT which will mean that their financial year-end position is likely to be in line with plan.

Bart's and BHRUT have flagged risks associated with the delivery of efficiency targets and excess inflation, which have been ongoing and will make it difficult for the break-even position to be achieved. Bart's and BHRUT have flagged a gross risk of £53m in relation to these risks. System wide discussions and discussions with the regulators have taken place, and whilst some mitigations have been identified there is still an unmitigated risk of £35m. It is expected, that this will be mitigated in part by £10.5m national funding which is available for hitting the expected target.

The table below summarises the risks and impact on the financial position.

Organisation / System wide	Description of risk	Risk Level	Potential Impact before mitigations £m	Potential Impact after mitigations £m
BHRUT	Efficiency - Delivery	High	(26.0)	(15.0)
Barts	Excess inflation risk for items included within plans	High	(27.0)	(20.0)
System Wide	National funding for hitting stretch target	High	0.0	10.5
Total Risk			**(53.0)**	**(24.5)**

As a result of the movement in position NHSE's deficit protocol will be enacted. The ICB CPFO is leading the process across the system to ensure that the relevant conditions and criteria within the deficit protocol are delivered.

There is also ongoing work across the ICS partner organisations to try to mitigate the current and future financial pressures. The ICB CPFO has constituted a finance recovery working group across the whole of the ICS. This will review and drive forward the in-year financial position, efficiency and savings target and oversee the development of a 5 year system financial plan.

Further updates on this will be given to Committee on this.

3. Month 8 Performance Overview

The Month 8 performance update provides NEL ICB with the latest published performance position which has been presented to the Finance, Performance and Investment Committee (FPIC) on the 27 February 2023.

The ICB Board is asked to note the information in the report and it is also worth mentioning that the Performance reported on here relates to month 8 (November 2022) due to the timing of published validated data by NHS Digital. The exception is urgent and emergency care (UEC) where data is more recent (month 9, December 2022). This report not only provides a summary of the performance position but also describes the risks and mitigations to the reported position.

Key headlines are;

3.1.1 - Planned Care

- The overall NEL referral to treatment waiting list fell in November 2022 due to a decrease in the number of patients waiting for treatment in an outpatient setting.
- The number of patients waiting for a year or more for their planned care continues to reduce.
- The number of patients being seen in NEL remains lower than planned, particularly in relation to inpatient activity. Inpatient activity in Nov-2022 was 95% of 19/20 levels. Consultant led outpatient activity was at 104% of pre-pandemic levels in Nov-22.

3.1.2 - Outpatient Transformation

- GPs are able to access specialist advice and guidance / referral assessment and triage. 28% of all first outpatient appointments were managed via this route in Nov-22.
- Patients were also able to initiate their own follow up appointments (PIFU) with the aim to reduce un-needed appointments / booking of follow-up appointments by default for 1.3% of all outpatient appointments in Nov-22, the highest volume at NEL level YTD.
- 19.5% of all outpatient appointments were delivered virtually (video/telephone) in Nov-22 across NEL

3.1.3 - Diagnostics

- There were 53,516 patients waiting for a diagnostic test in NEL this month and 8,259 patients had been waiting more than six weeks.
- NEL continues to see improvements in performance but still has the highest volume of patients waiting an imaging investigation in London in Nov-22.

3.1.4 - Cancer

- In Nov-22, NEL delivered five of the nine cancer waiting time constitutional standards for patients. However, treatment for patients within 62 days from urgent GP referral still requires improvement.

3.1.5 Urgent & Emergency Care

- In Dec-22, 1,276 arrivals by ambulance at NEL emergency departments (EDs) took more than 1-hour to be transferred from London Ambulance service care . 77% of all handovers took place within 60 minutes a marginal deterioration from 79% in Nov-22.
- 20% of arrivals by ambulance were handed over from London Ambulance service care within 15 min of arrival at ED.
- 48% of arrivals by ambulance were handed over within 30 mins of arrival at ED.

- In Dec-22, 60% of all patients were seen within 4-hours of arrival at ED.

3.1.6 - Health Services in the Community

- The volume and rate of appointments in GP practices has increased and patients are attending GP practices at a higher rate than prior to the pandemic.
- NEL aims to meet community waiting list trajectories by the end of Quarter 4 (March 2023).

3.1.7 - Mental Health

- A number of measures of service performance have improved when compared with the end of 2021/22. However, the plans set for the end of 2022/23 remain at some risk, as the rate of improvement needs to increase substantially.
- Services of note are; Improving Access to Psychological Therapies (IAPT, Talking Therapies), Children and Young People's (CYP) mental health access, Perinatal mental health support to women, Dementia diagnosis, and Physical Health Checks for people with Serious Mental Illness (SMI).

3.1.8 - Month 8 Performance Risks, Challenges and mitigations:

- **Planned Care** – there is a risk with the number of patients continuing to wait for 18 months or longer. This has an implication for 2023/24 and challenges the delivery of required levels of inpatient and outpatient activity to manage new referral demand, sustain/reduce the overall waiting list, and reduce long waits.

  Productivity programmes are in place at all three NEL Trusts (at hospital site level) with the aim to improve inpatient activity via improved theatre productivity and utilisation.

- **Outpatient Transformation -** there is risk with continued growth in the number of patients awaiting outpatient appointments and treatment.

  As a mitigation to this there is ongoing work to ensure patients waiting are equipped with the information they need, including support and advice to ensure they are able to 'wait well'. Additionally, programmes of work will continue to look at specialties experiencing significant growth.

- **Diagnostics** - Risks highlighted at Homerton in relation to sickness related absences and available staffing, resulting in clinic cancellations.

  As a system, NEL ICB is working to reduce long waiters, with focus on ensuring all patients waiting over 26 waits are reviewed and/ or have a date, managed via the local recovery programme.

- **Cancer –** Risks are flagged in imaging and histopathology that are impacting on cancer delivery across the system.

  NEL has introduced tele dermatology at BHRUT and Barts.

- **UEC –** Staffing shortages present risk to both 4hr performance and ability to take handovers from Ambulance Crews across NEL**.**

As a system, site-by-site review of actual practice and best practice across NEL for Ambulance Handovers is ongoing.

- **Health Services in the Community** - there is a risk with data quality in GP appointments data, increased demand for learning disability health checks in Quarter 4 and waiting lists in community services.

- **Mental Health -** There remains risk in relation to delivery of required levels of service improvement, and achieving year end performance will be challenging.

  As a system, there are recovery plans in place for IAPT (Talking Therapies), Children and Young People's (CYP), and Perinatal Access. These recovery plans are supported by clinically led NEL wide groups.

NEL ICB has systems and processes in place to ensure all performance measures across different frameworks are closely monitored, prioritised and escalated where appropriate.

3.1.9 – Recent performance issues

The reporting period for this set of data is of necessity some months in arrears. Since November 2022 there have been some significant events and movements:

- **Industrial action** – there have been four days of action in the ambulance service, and the local system coped well with the constraints. The 72-hour strike action by the junior doctors in March 2023 led to the rescheduling of around 600 planned care procedures and 8000 outpatient appointments. This was required to release consultant staff to focus on urgent and emergency care (UEC) patients. The NE London system was not directly affected by the nurses' industrial action called by the RCN.
- **Planned Care** – the total waiting list rose in December 2022, against the trend of the previous 6 months, but remains below the modelled trajectory figure
- **UEC** – all the measured factors improved in January 2023 from the local and national low point in performance in December 2022
- **Health services in the Community** – in general, the performance against trajectory continues to positive, with 6 of the 7 measured factors showing improvement.

4. Contracting 23/24

- The contracting round is currently underway for 23/24. The ICB is required to have fully signed contracts in 23/24. NHS England have provided guidance on the approach to contracting which has changed significantly from last year with a return to a cost and volume approach for acute contracting for elective services. NHS provider contracts are awarded on an annual basis without a procurement process. Full contract documents cannot be shared due to commercial sensitivity however can be made available to Board members on request.

- The contracting round runs in parallel to the Operational Planning process and needs to reflect the targets and financial allocations agreed as part of that process.

- NEL ICB host contracts for our local NHS acute, community and mental health providers on behalf of our population and for associate ICBs, both in and outside London. This year, the ICB will again host on behalf of Specialised Commissioning

as delegation of secondary care services (except secondary dental) has been delayed.

- After signature, a contract may be amended by agreement of a 'contract variation'. This mechanism can be used to add schedules that have yet to be agreed at contract signature (long-stop), new specifications or to add associates.

- **Recommendation: The Board is asked to delegate authority under the Scheme of Reservation and Delegation (SORD) for signature of contracts and contract variations to the Chief Finance Officer and one other Chief Officer in order that contract documentation is signed in a timely manner.**

Provider	ICB Contract Value	Delegated authority for signature to Chief Finance Officer and one other officer.
Barts Health NHS Trust - Acute Services	c£790m (excludes ERF)	Signature of contract including financial values, CQUIN. Subsequent contract variations to include other ICBs and Specialised Services and other long stopped schedules e.g. elective recovery plans, indicative activity plan (IAP), information schedule, performance metrics, data quality improvement plan (DQIP). Any subsequent variations to reflect changes to pay awards.
Homerton Healthcare NHS Foundation Trust, Acute Services	c£242m contract value (excludes ERF)	Signature of contract expected contract value, Longstop CV, CQUIN, IAP and non-recurrent transformation schemes commenced in 22/23 and continuing into 23/24. Subsequent contract variations in year to include non-recurrent SDF, winter pressures, virtual ward, service pilots (currently identified c£580K) and ageing well schemes.
Barking, Havering and Redbridge Hospital Trust	c£530m (excludes ERF)	Signature of contract including financial values, CQUIN. Subsequent contract variations to include other ICBs and Specialised Services and other long stopped schedules e.g. elective recovery plans, indicative activity plan (IAP), information schedule, performance metrics, data quality improvement plan (DQIP). Any subsequent variations to reflect changes to pay awards.
London Ambulance Service	c£107m	Signature as associate to the host NWL ICB contract and any CVs for subsequent service developments, pay awards etc.
Associates to 20 other ICB contracts across London and the South East	c£220m in total	Signature as associate to the host ICB's contract and any CVs for subsequent service developments, pay awards etc.
Homerton Healthcare NHS Foundation Trust, Community Services	c£40m contract value	Signature of contract expected to include contract value, Longstop CV, CQUIN, non-recurrent transformation schemes commenced in 22/23 continuing into 23/24. In year variations to include new SDF, winter pressures, ageing well schemes and non-recurrent service pilots (currently forecast to be c£916K).
North East London Foundation Trust Mental Health contract	c£173m	Signature of contract including financial values, CQUIN. Subsequent contract variations to include other ICBs and other long stopped schedules e.g. indicative activity plan (IAP), information schedule, performance metrics, data quality improvement plan (DQIP).
East London Foundation Trust Mental Health contract	c£190m	Signature of contract including financial values, CQUIN. Subsequent contract variations to include other ICBs and other long stopped schedules e.g. indicative activity plan (IAP), information schedule, performance metrics, data quality improvement plan (DQIP). Any subsequent variations to reflect changes to pay awards.
North East London Foundation Trust Community Contract	C£138m	Signature of contract including financial values, CQUIN. Subsequent contract variations to include other ICBs and other long stopped schedules e.g. indicative activity plan (IAP), information schedule, performance metrics, data quality improvement plan (DQIP).
East London Foundation Trust Newham CHS 22-24 Contract	c£39million per annum (£=c£80million across the two years)	Signing of 22-24 contract (22-23 + one year extension for 23-24)
Barts Health Community Contract Tower Hamlets Contract Variation	C£17m	Contract in place until end March 2024. CV to be signed covering CQUIN and 2023_24 finances.
East London Foundation Trust Tower Hamlets Community Contract Variation	C£20m	Contract in place until end March 2024. CV to be signed covering CQUIN and 2023_24 finances.

Attachment: Appendix 1 – Month 10 2022-23 Financial Reporting – Supporting Information Pack
Appendix 2 – Performance Report ICS Board M8 Nov-22 FINALv2

NHS North East London ICB Board

29 March 2023

Title of report	Board Assurance Framework
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery, Chief Participation and Place Officer
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Executive summary	The paper outlines progress to date and presents the updated Board Assurance Framework (BAF) which captures the highest risks to meeting the integrated care system (ICS) aims, our purpose and four priorities. The BAF has been refined and updated following the feedback received at the March Board meeting and subsequent meeting of the Chair, Audit Chair and lead executive on 28 February. This update includes the realignment of some risks against the strategic ICS aims, an edit of wording to bring greater clarity and inclusion of four additional risks covering mutual accountability for our operating plan, our anti-racist commitment, digital and estates infrastructure; and focus on being outward looking as well as NEL focussed. The last Audit and Risk Committee considered the internal audit review of governance and risk, a largely positive report, but with helpful recommendations for improvement. These will be addressed, along with external audit feedback, in the next version of the BAF. Further discussion on risk appetite will take place with the Board ahead of the next meeting, with initial scores included for consideration. The current key risks on the BAF relate to: • Collaborative working across partners • Wider determinants of health/environment • Quality and safety of care • Delivery against control total and operating plan • Workforce • Population growth • Mutual accountability for commitments • Digital and estates • Anti-racist commitment • Being outward looking
Action required	To consider and note the updated Board Assurance Framework.
Previous reporting	ICB executive management team
Next steps/ onward reporting	• Audit and Risk Committee for assurance.

	• ICB and ICS executive management team to review the corporate risk register in February. • Board to receive updated BAF in May 2023
Conflicts of interest	N/A
Strategic fit	Implementing the risk strategy and policy for the ICB will support achievement of the ICB's corporate objectives through managing risks to delivery. It relates to all ICS aims: • 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 paper sets out key risks within the ICB and system in order to achieve our aims for the health and wellbeing of our population.
Impact on finance, performance and quality	Relates to achievement of our corporate objectives on these matters.
Risks	This report relates specifically to risk. The key risk in relation to this process is ensuring that we retain high levels of delegation but ensure a joined-up approach to ensure proper management and oversight of risk both locally and NEL wide.

1.0 Background

1.1 As both a statutory NHS organisation and the integrated care system (ICS) convener, the Integrated Care Board's risk register includes those risks affecting delivery of the wider ICS aims, purpose and objectives. The purpose of the Board Assurance Framework (BAF) is to set out the key risks to the Integrated Care Board (ICB) in achieving its objectives and priorities and to identify the controls and actions in place to manage those risks.

1.2 The ICB has a responsibility to maintain sound risk management processes and ensure that internal control systems are appropriate and effective and where necessary to take remedial action. It is a key part of good governance. The risk review uses the standard NHS methodology that considers the likelihood of the risk alongside the severity of its impact if it materialises. The risk score takes account of the mitigating action proposed. This then gives a risk score and categorisation of:

1-3 Low Risk Low Priority	**4-6 Medium Risk Moderate Priority**	**8-12 High Risk High Priority**	**15-25 Very High Risk Very High Priority**

1.3 The BAF is constructed around the aims of the ICS:

- 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

As the ICB and system develops over the year, a full set of strategic objectives will be established and in place for April 2023. These are included for approval with the Chief Executive's report to this meeting. The BAF will be updated monthly to reflect the progress being made, as well as to identify any new risks.

2.0 Risk appetite

2.1 Following the last board meeting, risk appetite levels have been identified for each risk in line with the grading on page 10 of the attached Board Assurance Framework.

3.0 Process for escalation

3.1 Risks managed through the Committees of the ICB that are rated 15 or above should be considered for escalation to the Board. The escalated risk will continue to be maintained in the Committee's and relevant Chief Officer portfolio register. In addition, risks raised through the Board and the Integrated Care Partnership will be considered for inclusion.

4.0 Progress to date

4.1 At the last meeting of the ICB Board, the Chair suggested a further meeting to consider the overall Board Assurance Framework and strategic risks involving the governance team, ICB Chair, Audit Chair and Chief Participation and Place Officer. The meeting took place on 28 February and the BAF has been updated following this. The updates include the realignment of some risks against the strategic ICS aims, an edit of wording to bring greater clarity and inclusion of four more covering

mutual accountability, our anti—racist commitment, digital and estates infrastructure; and focus on being outward as well as NEL focussed.

4.2 Since the last Board meeting, internal audit have finalised the report on the governance and risk audit which was considered at the Audit and Risk Committee meeting on 15 March. Overall this is a broadly positive report, but does indicate some areas for improvement in relation to risk management, largely from a compliance rather than design perspective. External audit have also advised that the target dates for risks should be reviewed to ensure they are realistic. The BAF and approach will be fully updated in advance of the May meeting of the Board to take on board the recommendations.

5.0 Risks on the BAF

5.1 The current risks, along with updated scores, escalated to the Board Assurance Framework are as follows, with the detail included in the appendix:

- There is a risk that ICS partners do not work together and with local people and communities in collaborative and strengths-based ways and so cannot deliver on our ICS purpose, aims and priorities. This could limit impact on improving the health and wellbeing of local people and reducing health inequalities.

- There is a risk that quality and safe care will be adversely affected, reflected in increasing inequalities, poorer outcomes and service failures, when we as a system do not seek to understand and prioritise the experience of local people and to act compassionately and collaboratively with them in response.

- There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents, thereby increasing health inequalities, poorer outcomes and service failures. This could also impact the ability to improve existing services and drive innovation, which in turn could lead to intervention from regulators such as the CQC.

- There is a risk that the failure to work together to produce and implement a coherent, whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support the wellbeing of our diverse workforce and deliver the range of services needed by local people, adversely impacting on their health and wellbeing.

- There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London. In addition, a failure to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a requirement to go into recovery and potential reductions in services to local people.

- There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.

- There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation; and social networks and connections.

The following **new** risks have been added to the BAF following the meeting with the lead executive, Chair and Audit Chair. Further work is underway to populate the detailed template and will be taken to the executive group for discussion and presented at the next meeting of the Board.

- There is a risk that specific populations may be adversely affected if the commitment to being an anti-racist system focussed on equality, diversity and inclusion, is not met. Effects could include poorer quality of care, outcomes and employment opportunities.

- There is a risk that as the ICB and partners focus on our system and financial challenges, that we become more inward focused and limit our opportunities to work with and influence wider partners across London impacting our ability to improve the health and wellbeing outcomes of local people and communities

- There is a risk that we are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population, due to underinvestment and limited options to secure investment. This could impact on our ability to deliver modern and safe care.

- There is a risk that if ICS partners do not share mutual accountability for the delivery of current and future operating plans and constitutional standards, this could result in clinical variation and negatively impact on quality and performance improvement. In turn, this could lead to poorer experience and outcomes for service users.

6.0 Next steps

6.1 The Head of Governance will continue to review the corporate risk register and meet with risk champions to review risks and current mitigations. The ICB and ICS executive team will continue to discuss the organisation and system wide risks to ensure further development and refinement of the BAF.

Board Assurance Framework March 2023 – Dashboard

North East London
Integrated Care Board

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score		Target	Risk Appetite – TBC by Board	Order in BAF
				Dec/ Jan	Feb/ Mar			
To improve outcomes in population health and healthcare	There is a risk that ICS partners do not work together and with local people and communities in collaborative and strengths-based ways and so cannot deliver on our ICS purpose, aims and priorities. This could limit impact on improving the health and wellbeing of local people and reducing health inequalities.	Johanna Moss	ICP Committee	**16 NEW RISK TO BAF**	**12** ↓	**8**	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**2**
To tackle inequalities in outcomes, experience and access	There is a risk that quality and safe care will be adversely affected, reflected in increasing inequalities, poorer outcomes and service failures, when we as a system do not seek to understand and prioritise the experience of local people and to act compassionately and collaboratively with them in response	Diane Jones	Quality, Safety and Improvement Committee	**20 NEW RISK TO BAF**	**20** ↔	**8**	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**5**
	There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents, thereby increasing health inequalities, poorer outcomes and service failures. This could also impact the ability to improve existing services and drive innovation, which in turn could lead to intervention from regulators such as the CQC	Diane Jones	Quality, Safety and Improvement Committee	**20 NEW RISK TO BAF**	**20** ↔	**8**	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**7**
	There is a risk that the failure to work together to produce and implement a coherent, whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support the wellbeing of our diverse workforce and deliver the range of services needed by local people, adversely impacting on their health and wellbeing.	Francesca Okosi	Workforce and Remuneration Committee	**12 NEW RISK TO BAF**	**12** ↔	**6**	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**6**
To enhance productivity and value for money	There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London. In addition, a failure to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a requirement to go into recovery and potential reductions in services to local people.	Henry Black	Finance, Performance and Investment Committee	**20** ↔	**20** ↔	**10**	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**1**
	There is a risk that we are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population, due to underinvestment and limited options to secure investment. This could impact on our ability to deliver modern and safe care.	Johanna Moss	Finance, Performance and Investment Committee	**N/A**	**New risk – scores to be determined**		**To be decided**	**New risk – framework to be developed**
	There is a risk that if ICS partners do not share mutual accountability for the delivery of current and future operating plans and constitutional standards, this could result in clinical variation and negatively impact on quality and performance improvement. In turn, this could lead to poorer experience and outcomes for service users.	Henry Black	Finance, Performance and Investment Committee	**N/A**	**New risk – scores to be determined**		**To be decided**	**New risk – framework to be developed**

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score		Target	Risk Appetite – TBC by Board	Order in BAF
				Dec/ Jan	Feb/ Mar			
To support broader social and economic development	There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.	Charlotte Pomery	Population Health and Integration Committee	16 ⟷	16 ⟷	8	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**4**
	There is a risk that as the ICB and partners focus on our system and financial challenges, that we become more inward focused and limit our opportunities to work with and influence wider partners across London impacting our ability to improve the health and wellbeing outcomes of local people and communities.	Charlotte Pomery	Population Health and Integration Committee	**N/A**	**New risk – scores to be determined**		**To be decided**	**New risk – framework to be developed**
	There is a risk that specific populations may be adversely affected if the commitment to being an anti-racist system focussed on equality, diversity and inclusion, is not met. Effects could include poorer quality of care, outcomes and employment opportunities.	Francesca Okosi	Executive Committee	**N/A**	**New risk – scores to be determined**		**To be decided**	**New risk – framework to be developed**
	There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation; and social networks and connections.	Paul Gilluley	Population Health and Integration Committee	16 **NEW RISK TO BAF**	16 ⟷	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**3**

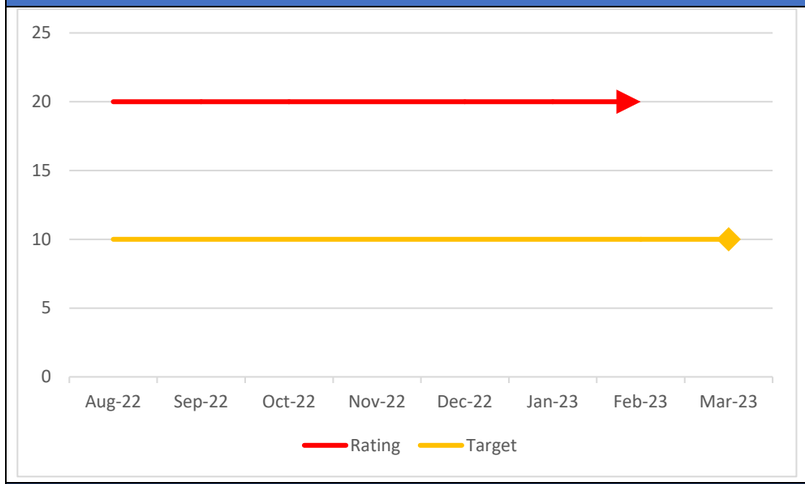
Board Assurance Framework – January 2023

ICS Aim	To enhance productivity and value for money				Risk applies to ICB	Risk applies to ICS	Risk reference	CFPO01
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Henry Black
	✓	✓	✓	✓			Responsible committee	Finance, Performance and Investment Committee

Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		

Risk description	There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London. In addition, a failure to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a requirement to go into recovery and potential reductions in services to local people.

Score history and targets

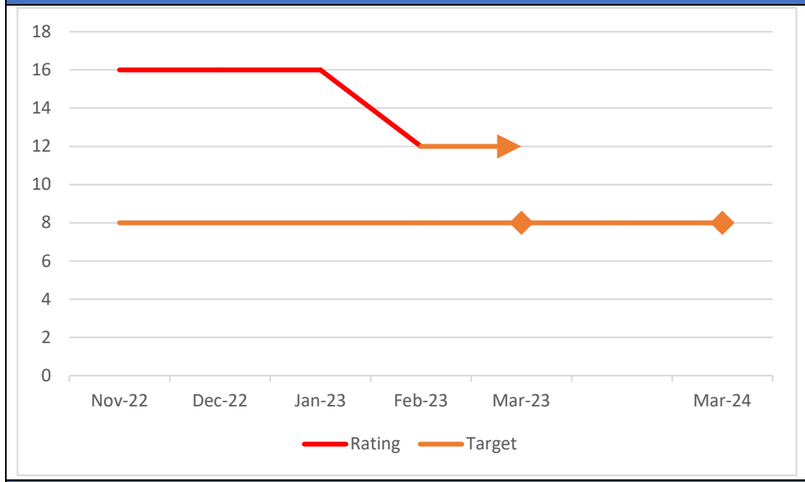


Initial rating (LxS)	Initial date	Rationale
20 (4x5)	August 2022	The system has a control total (CT) agreed with NHSE that is required to be delivered. There is considerable risk at present to achievement of the CT due to lack of long-term transformation and delivery of cost improvement programmes (CIPs), elective recovery backlog, winter pressures and workforce shortages. The risk goes beyond a financial risk and impacts on all areas of the system.
Target rating (LxS)	**Target date**	**Rationale**
10	March 2023	Mitigations in place should aid the reduction in the risk score and allow the system to deliver its statutory financial duty. However, the prerequisite to this is the reduction in spend across the system.
Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
20 (4x5)	March 2023	The system has a control total (CT) agreed with NHSE that is required to be delivered. There is considerable risk at the end of the year on the achievement of the CT for this financial year; with greater risk showing for subsequent years due to lack of long-term transformation and delivery of cost improvement programmes (CIPs), elective recovery backlog, winter pressures and workforce shortages. The risk goes beyond a financial risk and impacts on all areas of the system.

Controls and assurances
Monthly system level reporting and ongoing review of specific financial risks and opportunities. Reports presented to the Executive Committee monthly and the Finance, Performance and Investment Committee bi-monthly.
Financial performance reported and reviewed by regional/national teams
Agreed Internal Audit and Counter Fraud Programmes with RSM which are reported to the bi-monthly Audit and Risk Committee
Annual External Audit with KPMG which is reported to the Audit and Risk Committee
Barking Havering and Redbridge University Hospitals Trust (BHRUT) have enhanced support from NHS England relating to system oversight framework (SOF) 4 position. Assurances are reported at meetings with regional and national teams.
Internal ICB processes to deliver greater transparency on future spend; including business case process where assurance is provided by the Business Case Assurance Group.

Mitigations/ actions to address the risk	Target date
ICS Chief Finance Officers (CFO) meetings with all system partners have been established with outcomes agreed.	Completed
Providers have been given additional funding for elective care (Elective Recovery Fund – ERF)	31.03.23
System-wide discussions are taking place to discuss the drivers of the deficit, via the financial recovery summit and system finance groups	31.03.23
System wide formal recovery programme to be stood up with key groups to take forward different areas of recovery; including workforce productivity, corporate services and temporary staffing.	31.03.23
System partners have internal efficiency programmes in place to deliver savings for this financial year	31.03.23
Finance team continues to identify ICB savings to be enacted for this financial year to be able to deliver the breakeven position that is statutorily required	31.03.23
Within the ICB - development of CIP and recovery plans for continuing health care (CHC) and prescribing.	31.03.23

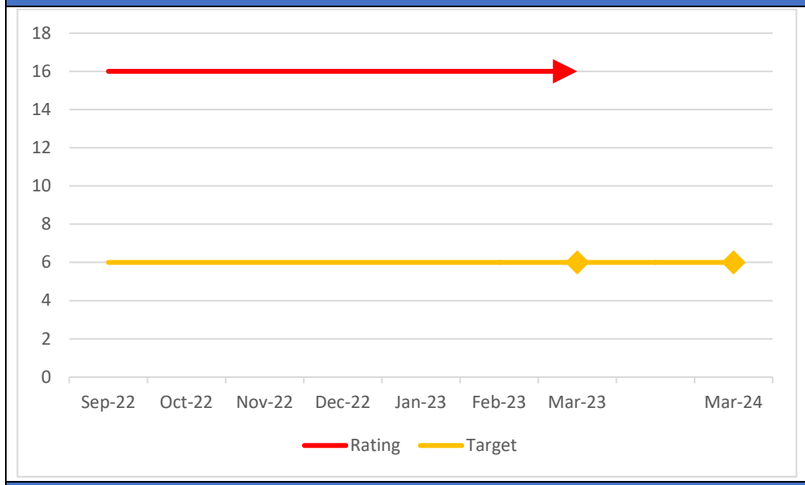
ICS Aim	To improve outcomes in population health and healthcare							Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO (no. tbc)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Johanna Moss
	✓		✓		✓		✓			Responsible committee	ICP Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓				
Risk description	There is a risk that ICS partners do not work together and with local people, communities and stakeholders in collaborative and strengths-based ways and so cannot deliver on our ICS purpose, aims and priorities and will have limited impact on improving the health and wellbeing of local people and reducing health inequalities.										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	Nov 2022	At the point of this risk being identified the extent of engagement required to co-produce the strategy whereby it was jointly owned by all partners was challenging. The reputational and operational impact of not developing a coproduced strategy would be severe as it's one of the key purposes of the ICP to provide the strategic framework for the local health system.
	Target rating (LxS)	**Target date**	**Rationale**
	8	March 2024	Significant work has been planned to ensure there is full engagement with a wide variety of stakeholders and partners reducing the likelihood.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	12 (4x3)	March 2023	This will always remain an important risk for the ICS which we will need to pay attention to. We secured ICS support for our integrated care partnership strategy in January as a result of the collaborative and joint approach adopted. We are building on this experience in our approach to developing our Joint Forward Plan

Controls and assurances
Review of current data and information including JSNAs from all 7 PBP and NEL population profile
ICP strategy development - key focus on securing PBP and provider collaborative input including engaging executives from provider collaborative e.g. Trust Chairs and Snr executives
ICP strategy discussed at CAG to ensure clinical engagement and input
ICP strategy task and finish group established to ensure system wide engagement and involvement
The ICB Executive Management Team, ICP Committee, to receive regular updates

Mitigations/ actions to address the risk	Target date
Task and finish group established with broad range of involvement from ICP system to oversee development and drafting of the strategy	Jan 2023
ICP strategy to be socialised at staff meeting, and shared with senior leadership for cascading to partners	March 2023
ICP strategy discussed at borough level with 8 x Health & Well Being Boards and 7 Place Based Partnerships	April 2023
PPE engagement on the ICP strategy through working with Healthwatch and CVS in NEL	May 2023
Series of workshops that include wide range of partners from across the system - over 200 attendees for BCYP and over 100 participants for all the others	Dec 2022

ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CMO (no. tbc)
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Paul Gilluley
	✓	✓	✓	✓			Responsible committee	Population Health and Integration Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		
Risk description	**There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation; and social networks and connections.**							

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	September 2022	NEL currently has the highest rates of air pollution in the UK and the impact of air pollution on ill health is known and individuals suffer harm because of it. The additional pressure put on the NHS system due to ill health arising from air pollution has a severe operational and reputational risk.
	Target rating (LxS)	**Target date**	**Rationale**
	6	March 2024	An ambitious target to contribute towards the reduction in air pollution locally as a system hence reducing the likelihood and thereby reducing the harm it causes to individuals and the impact on NHS as a whole.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	16 (4x4)	March 2023	

Controls and assurances
ICS Net Zero SROs meet regularly as a system group
Reports presented to the Population health management and health inequalities steering group
Reports presented to the Population Health and Integration Committee

Mitigations/ actions to address the risk	Target date
Work with ICB partners to promote and support active staff travel approaches across NEL including walking, cycling and use of public transport	Ongoing commitment to promote active travel
Introduce low emission car rental scheme	Complete - December 2022
Scoping requirements and need for an air quality strategy for NEL including clinical lead and PMO support to be in place to champion air quality and drive strategic relationships with wider system to focus on addressing air quality and to highlight health cost of poor air quality on people's health outcomes	May 2023
Travel and transport working group established with involvement from across ICB system	July 2023
Introduced salary sacrifice staff bike scheme across ICB	Complete - Jan 2023

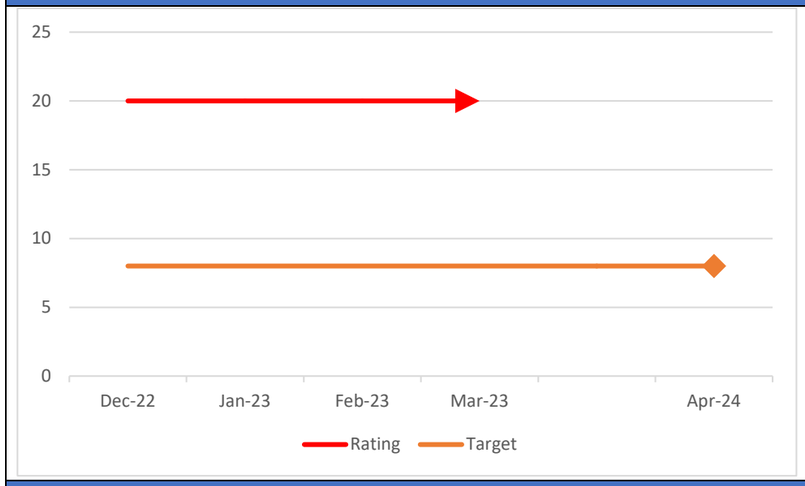
ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO11
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Charlotte Pomery
	✓	✓	✓	✓			Responsible committee	Population Health and Integration Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		
Risk description	There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.							

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	16 (4x4)	November 2022	Given the rapid population growth expected in north east London, there is a need to develop the infrastructure required to support people's health and wellbeing against a challenging economic backdrop.
	Target rating (LxS)	**Target date**	**Rationale**
	8	March 2024	Establishment of the ICS and ICB and all associated structures and governance are still in progress which keeps this as a risk
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	16 (4x4)	March 2023	As above, mitigating actions are still in progress and not yet in place/resolved

Controls and assurances
The implementation of ICB and ICS governance structures which include various committees and sub-committees which are held on monthly or bi-monthly basis with ICS partners. Minutes of these meetings can be provided for assurance

Mitigations/ actions to address the risk	Target date
Establishment of Local Infrastructure Forums	March 2024
Development of long-term Strategic Infrastructure Approach	March 2024
Dedicated work with local authorities through Place Partnerships and cross-Place Partnership working	March 2024
Progress of development projects such St George's, Havering and the Ilford Exchange in Redbridge.	March 2024

ICS Aim	To tackle inequalities in outcomes, experience and access							Risk applies to ICB	Risk applies to ICS	Risk reference	CNO (no. tbc)
									✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Diane Jones
	✓		✓		✓		✓			Responsible committee	Quality, Safety and Improvement Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓				
Risk description	There is a risk that quality and safe care will be adversely affected, reflected in increasing inequalities, poorer outcomes and service failures, when we as a system do not seek to understand and prioritise the experience of local people and to act compassionately and collaboratively with them in response										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	20 (5x4)	December 2022	Considerable system risks that may have an impact on quality and safe care
	Target rating (LxS)	**Target date**	**Rationale**
	8	April 2024	Significant programmes of work are planned or underway that will enable greater oversight across the System
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	20 (5x4)	March 2023	Programme Boards and improved ways of working/ collaboration across the system are starting to be explicit that should result in good practice and greater collaboration becoming embedded

Controls and assurances
Incident Management calls across the ICS have been implemented.
System Oversight Command Group stood up across NELHCP.
The NEL System Quality Group meets quarterly to discuss System Quality issues
Mental Health/ Learning Disability and Autism (MHLDA) Programme Board in place to review System MHLDA issues
Urgent and Emergency Care Programme Board in place to review system UEC risks and programmes of work to support improvement
Partnership of East London Co-operatives (PELC) Assurance and Improvement Groups meets to assure PELC actions against Care Quality Commission actions and support improvement conversations across NHR geography
Quality, Safety and Improvement Committee (QSI) in place to review System/ Place quality issues

Mitigations/ actions to address the risk	Target date
Escalation discussions taking place across London Chief Nurse network and Chief Medical Officer network - also replicated across NELHCP	
Consideration to be given to areas of clinical activity that could be stood down if needed.	
Review the possibility of requesting additional clinical support across the system and possible redirection of clinical support	
After Action Review and Clinical Harm Review processes to be determined	
Impact of industrial action discussion at QSI Committee	08/02/23
System programmes to support UEC improvements discussion at QSI Committee	08/02/23

ICS Aim	To tackle inequalities in outcomes, experience and access		Risk applies to ICB	Risk applies to ICS	Risk reference	CPCO02
				✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions	Risk owner	Francesca Okosi
			✓		Responsible committee	Workforce and Remuneration Committee

Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		

Risk description	There is a risk that the failure to work together to produce and implement a coherent, whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support the wellbeing of our diverse workforce and to deliver the range of services needed by local people with adverse impacts for their health and wellbeing.

Score history and targets

Initial rating (LxS)	Initial date	Rationale
12 (3x4)	December 2022	Given our current service requirements and workforce pressures, that cuts across organisations, if we do not plan and deploy effectively we will not be in a position to deliver the range of services required. And, may impact on the health and well-being of our workforce.
Target rating (LxS)	**Target date**	**Rationale**
6 (2x3)	March 2024	To ensure a consistent and health and well-being offer is maintained for all staff across north east London (NEL). Plans developed and in place to allow flexible deployment and minimum employment of staff across NEL. Development of new roles that can be trained and deployed quickly to NEL utilising apprentice pathways, new roles and retention initiatives. Also to ensure pathways and processes are in place to support and encourage local people into health and care employment.
Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
12 (3x4)	March 2024	Engagement with system partners has started, however there has been delays to the target dates for mitigating actions to address the risk; therefore, the rating has maintained its score.

Controls and assurances
Workforce workshop held 1 November 2022.
High level strategy for discussed at ICB EMT in March 2023
Presentation of the outline strategy to Workforce and Remuneration committee in February 2023
Final strategy for approval and sign off at Executive Leadership Team end of March 2023

Mitigations/ actions to address the risk	Target date
Initial engagement with Local Authorities, providers voluntary sector since October 2022	Completed – engagement continues as required
High level outline drafted for overall ICS strategy.	Completed - January 2023
Further engagement with all system partners on further shaping and developing the strategy	Completed - January 2023. Engagement will continue through to mid-April 2023
Draft strategy document to be completed by 30 April and ready for review	30 April 2023
Outline workforce strategy to be signed off by May 2023.	May 2023
Confirmation of funding to continue the Keeping Well offer for staff into 23/24	April 2023
Set up a task and finish group to develop and agree a minimal employment offer and flexible deployment of staff	September 2023
Ensure full utilisation of the levy and infrastructure to support learning in the workplace. Building cohorts of up skilled staff incrementally	January 2024
Through existing health and care recruitment hubs a commitment to offer 900 posts to local residents - incrementally up to 2024 funded by the GLA	January 2023 and ongoing

ICS Aim	To tackle inequalities in outcomes, experience and access							Risk applies to ICB	Risk applies to ICS	Risk reference	CNO (no. tbc)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Diane Jones
	✓		✓		✓		✓			Responsible committee	Quality, Safety and Improvement Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓				
Risk description	**There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents, thereby increasing health inequalities, poorer outcomes and service failures. This could also impact the ability to improve existing services and drive innovation, which in turn could lead to intervention from regulators such as the CQC.**										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**20 (5x4)**	December 2022	Considerable resource and workforce capacity risks that may have an impact on quality and safe care
	Target rating (LxS)	**Target date**	**Rationale**
	8	April 2024	Significant programmes of work are planned or underway that will enable greater oversight across the System
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	20 (5x4)	March 2023	Range of Boards in place and improved ways of working/ collaboration across the system are starting to be explicit that should result in reduction in risk

Controls and assurances
Incident Management calls across the ICS have been implemented.
System Oversight Command Group stood up across NELHCP.
The NEL System People Board are in place
Recruitment across Clinical Leadership roles to support improvement programmes to address risk ie Director of Allied Health Professionals role
International recruitment campaigns in place across all NEL Providers i.e. NELFT programme in Africa
Nursing and Midwifery Workforce Expansion Board – regional group to deliver against the Government promise to increase nursing and midwifery numbers

Mitigations/ actions to address the risk	Target date
Escalation discussions taking place across London Chief Nurse network and Chief Medical Officer network - also replicated across NELHCP	
Consideration to be given to areas of clinical activity that could be stood down if needed.	
Review the possibility of requesting additional clinical support across the system and possible redirection of clinical support	
Nursing retention discussions ongoing across NEL	
Impact of industrial action discussion at QSI Committee	08/02/23
System programmes to support UEC improvements discussion at QSI Committee	08/02/23

SUPPORTING INFORMATION

Appetite description	Appetite level
Averse: Avoidance of risk is a key objective	1
Cautious: We have limited tolerance of risk with a focus on safe delivery	2
Open: We are willing to take reasonable risks, balanced against reward potential	3
Bold: We will take justified risks.	4

Committees of the Integrated Care Board:

- Population Health and Integration Committee
- Quality, Safety and Improvement Committee
- Audit and Risk Committee
- Finance, Performance and Investment Committee
- Workforce and Remuneration Committee
- Executive Committee

Aims of the Integrated Care System:

- 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

Risk grading matrix

Risk Category	
	Severe
	High
	Medium
	Low

	Rating	Description	A Objectives/ projects	B Harm/injury to patients, staff visitors & others	C Actual/potential complaints & claims	D Service disruption	E Staffing & competence	F Financial	G Inspection/ Audit	H Adverse media	Likelihood
											Rating
											Description
											Probability
Severity	**1**	**Insignificant**	Insignificant cost increase/time slippage. Barely noticeable reduction in scope or quality	Incident was prevented or incident occurred and there was no harm	Locally resolved complaint	Loss/ interruption more than 1 hour	Short term low staffing leading to reduction in quality (less than 1 day)	Small loss <£1000	Minor recommendations	Rumours	1
	2	**Minor**	Less than 5% cost or time increase. Minor reduction in quality or scope	Individual(s) required first aid. Staff needed <3 days off work or normal duties	Justified complaint peripheral to clinical care	Loss of one whole working day	On-going low staffing levels reducing service quality	Loss of 0.1% budget.	Recommendations given. Non-compliance with standards	Local media	2
	3	**Moderate**	5-10% cost or time increase. Moderate reduction in scope or quality	Individual(s) require moderate increase in care. Staff needed >3 days off work or normal duties	Below excess claim. Justified complaint involving inappropriate care	Loss of more than one working day	Late delivery of key objectives/service due to lack of staff. On-going unsafe staff levels. Small error owing to insufficient training	Loss of more than 0.25% of budget.	Reduced rating. Challenging recommendations. Non-compliance with standards	Local media lead story	3
	4	**Major**	10-25% cost or time increase. Failure to meet secondary objectives	Individual(s) appear to have suffered permanent harm. Staff have sustained a "major injury" as defined by the HSE	Claim above excess level. Multiple justified complaints	Loss of more than one working week	Uncertain delivery of services due to lack of staff. Large error owing to insufficient training	Loss of more than 0.5% of budget.	Enforcement action. Low rating. Critical report. Major non-compliance with core standards	Local media short term	4
	5	**Severe**	>25% cost or time increase. Failure to meet primary objective	Individual(s) died as a result of the incident	Multiple claims or single major claims	Permanent loss of premises or facility	No delivery of service. Critical error owing to insufficient training	Loss of more than 1% of budget.	Prosecution. Zero rating. Severely critical report.	National media more than 3 days. MP concern	5

Likelihood					
Rating	**1**	**2**	**3**	**4**	**5**
Description	**Rare**	**Unlikely**	**Possible**	**Likely**	**Certain**
Probability	**<10%**	**10% - 24%**	**25% to 45%**	**50% - 74%**	**>75%**
1	**1**	**2**	**3**	**4**	**5**
2	**2**	**4**	**6**	**8**	**10**
3	**3**	**6**	**9**	**12**	**15**
4	**4**	**8**	**12**	**16**	**20**
5	**5**	**10**	**15**	**20**	**25**

North East London
Integrated Care Board

NHS North East London ICB board

29 March 2023

Title of report	Executive Committee exception report
Author	Katie McDonald, Governance Manager
Presented by	Zina Etheridge, Chief Executive Officer
Contact for further information	Katie McDonald, Governance Manager katie.mcdonald3@nhs.net
Executive summary	This report provides a summary of the key items from the meetings of the Executive Committee held on 9 February 2023 and 9 March 2023. The key items detailed in the report include: • Establishment of the Clinical Advisory Group as a sub-committee of the Executive Committee • The transfer of London-wide Pharmacy, Optometry and Dental Services (PODS) • Approach to operational planning • Making north east London a Living Wage Place • Place partnership mutual accountability framework.
Action required	Note
Previous reporting	None – this is an exception report from the meetings held in February and March 2023.
Next steps/ onward reporting	The committee meets again on 6 April 2023 and a regular exception report will be presented to the Board.
Conflicts of interest	There are no conflicts of interest identified in relation to this report.
Strategic fit	The ICS aims this report aligns with are: • 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 committee has an overall focus on addressing inequalities, reducing variation and improving equity for all the people of north east London while ensuring participation and co-production is central to our collective approach.
Impact on finance, performance and quality	The committee is established to provide executive oversight of the ICS system budget and financial delegations to ensure delivery of system control total and financial improvement trajectory. Provide executive oversight of system finance and associated risks. Ensure opportunities for bidding for transformational funding are maximised and provide oversight of

	bids. Approve matters in line with the scheme of reservation and delegation.
Risks	The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

1.0 Purpose of the report

1.1 This report provides a summary of the key items from the meetings of the Executive Committee held on 9 February 2023 and 9 March 2023.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 In February the committee received a report which explained that since the Board's approval of the Governance Handbook, there had been further discussion on the establishment of the Clinical Advisory Group as a sub-committee of the Executive Committee. The Clinical Advisory Group had been operating as a standalone meeting with no formalised reporting mechanism to a committee of the Board and therefore it was recommended that the Clinical Advisory Group should be established as a sub-committee of the executive committee and will report on its activity to the committee on a monthly basis, in order to provide a clinical voice to executives. The committee approved the proposal and the Clinical Advisory Group has been meeting fortnightly as a sub-committee since 1 March 2023.

2.2 At both February and March meetings the committee received update reports regarding the transfer of London-wide Pharmacy, Optometry and Dental Services (PODS). NHS England will be transferring the London-wide PODS to ICBs from April 2023 and all London ICBs have agreed the commissioning and operating model for delegated functions across London. North East London ICB has been supported to host the PODS Hub team on behalf of all five London ICBs. NEL ICB will host the London-wide POD services for a transitional period of at least 18 months until such time as individual London ICBs have developed their own commissioning and contract management arrangements. The staff transfer of the PODS Hub team to NEL ICB will take place on 1 July 2023. The region will host the team on behalf of the London ICBs for the first quarter of the year until this date. This will be underpinned with the delegation arrangements and memorandum of understanding with each ICB, to ensure the right conditions are in place for a successful transfer. The committee noted that the responsibility for managing primary care complaints will also be transferred from NHS England to ICBs and a report regarding this will be presented at a future meeting.

2.3. Extensive work has happened across the system in preparation for submitting the 2023/24 operating plan to NHS England on 30 March 2023, which was highlighted at both committee meetings in February and March. The committee discussed the importance of transparency within the system in relation to budgets and efficiencies in order to deliver a viable plan. It had been highlighted that consideration should also be given to triangulating quality with activity, performance, workforce and finance so that quality of care is not compromised for residents. In relation to the operating plan, the committee discussed how the Community Collaborative Sub-committee could assist with exploring an increased virtual ward offer for certain specialities which would enable patients to receive treatment at home or closer to

home rather than be admitted to hospital. Members were also mindful of the digital poverty faced in some communities and were keen to explore various models in order to not exacerbate health inequalities.

2.4 On 9 March 2023 the committee welcomed a report regarding making north east London a Living Wage Place, including NHS Trusts, GP practices, local authorities, and social care providers. As a large employer across north east London there is a need to ensure that staff and contractors are paid a liveable wage so that they can maintain good health and a quality of life that does not widen health inequalities, which can in turn reduce pressure on the health and care system. Making a commitment to the London Living Wage would be a practical way of reducing the strain on the current cost of living crisis faced by residents. A report will be brought to the next Board meeting on 31 May 2023 to discuss reconfirming the commitment, as per the anchor charter, for the ICS to become a London Living Wage system.

2.5 At its meeting on 9 March, the committee received a report which explained the place partnership mutual accountability framework. The framework has been developed with north east London's place partnerships and aims to establish a common understanding of shared ambitions, mutual expectations, and way of working between place partnerships and other parts of north east London's integrated care system. It sets out the role of place partnerships in delivering the integrated care system's strategic objectives, alongside local priorities. It also contains metrics to underpin place partnerships' accountability for improving local quality and performance. It concludes by explaining how NHS North East London will support place partnerships in each of these areas. A similar and interlinked framework for the collaboratives is being developed with partners and will be brought to a future committee meeting. The committee welcomed the framework and noted the progress that has been made since forming the Integrated Care System and members expressed how the new ways of working have changed health and care culture to form a true partnership.

3.0 Risks and mitigations

3.1 The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

North East London
Integrated Care Board

NHS North East London ICB board

29 March 2023

Title of report	Audit and Risk committee exception report
Author	Cha Patel, Audit & Risk committee chair
Presented by	Cha Patel, Audit & Risk committee chair
Contact for further information	anna.mcdonald@nhs.net
Executive summary	This report provides a summary of the key items from the meeting held on 1 February 2023 and a verbal update will be given on any key messages from the meeting held in March.
Action required	The board is asked to note the report.
Previous reporting	The previous report related to the meeting of 7 December 2023.
Next steps/ onward reporting	The committee meets again on 24 April 2023 and a further report will be presented to the Board.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	The ICS aims this report aligns with are: • 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 remit of the committee is to contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management, internal control processes and arrangements to manage conflicts of interest within the ICB.
Impact on finance, performance and quality	N/A
Risks	The Committee will be driven by the organisation's objectives and the associated risks and its duties will be governed by the Terms of Reference. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1 The board is asked to note this report.

2.0 Key messages

2.1 It was noted that whilst disaggregated pension data was not available to determine NHS North East London's (NEL) position, for the purposes of reporting in the annual accounts, the treatment by auditors would be consistent with other organisations.

2.2 Progress continues to be made in managing the procurement process particularly around single tender waivers. The mandatory move to a new system from April 2024 would require 100% PO compliance so this will be a focus area for the committee.

2.3 Committee members will be reviewing the Annual Report prior to submission to the ICB board.

2.4 Risk Management systems within London Integrated Care Systems (ICS) are no further advanced in comparison to NEL. RSM and we have asked to be kept advised of best practice elsewhere.

2.5 An update on the External Audit plan was received and noted. Internal Auditor reports on IR35 arrangements and Primary Care commissioning were received. Action plans arising are expected to be completed on time although it was hoped the IR35 arrangements could be completed earlier subject to capacity within HR.

2.6 Training in regard to conflicts of interest and counter fraud is progressing.

2.7 Whilst a year-end financial position has been agreed with NHS England, the outcome remains very challenging.

3.0 Risks

3.1 Information Governance Training would need a significant push from the current 75% to achieve target of 95%.

3.2 Business Intelligence Services transferring from London Shared Services would also transfer their responsibilities and liabilities and any risks would need to be identified and managed in addition to overarching system risks.

3.3 Staffing capacity constraints in procurement challenge mandated requirements.

3.4 Achieving a break-even position in the next financial year will be very challenging with elements of one-off funding being unavailable.

Author: Cha Patel

North East London
Integrated Care Board

NHS North East London ICB board

29 March 2023

Title of report	Workforce and Remuneration committee exception report
Author	Anna McDonald, Senior Governance Manager
Presented by	Diane Herbert, Non-executive member
Contact for further information	anna.mcdonald@nhs.net
Executive summary	This report provides an overview of key items from the meeting held on 22 February 2023.
Action required	The board is asked to note the report.
Previous reporting	None – this is an exception report from the meeting held on 22 February 2023.
Next steps/ onward reporting	The committee meets again on 4 April 2023 and an exception report will be presented to the board going forward.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	Employment and workforce – to work together to create meaningful work opportunities and employment for people in north east London now and in the future.
Impact on local people, health inequalities and sustainability	The Committee will receive assurance on the ICB's Employment Flagship Priority, ensuring that we utilise the ICB's ability to provide meaningful and positive employment opportunities for local residents.
Impact on finance, performance and quality	The Committee and all of its members are bound by the ICB's Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB.
Risks	The Committee will be driven by the organisation's objectives and the associated risks and its duties will be governed by the Terms of Reference. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1 The purpose of this report is to provide an overview of the agenda items discussed at the February meeting.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The committee received an update in regard to progress made in relation to the clinical care leader population which is in line with other London ICBs.

2.2 The committee received a verbal update on the re-organisation and the reason for the decision to pause the consultation process until after Easter.

2.3 A further update on the continued development of the ICS People and Workforce Strategy was received. Members were informed of the plans to hold a workshop at the end of March 2023 to agree the high-level strategy which will be presented to the committee at its meeting in April 2023.

2.4 An update on the very latest strike action was communicated and the committee discussed the added impact on staff across the system from the teachers strike and rail workers strikes.

3.0 Risks and mitigations

3.1 The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

Author: Anna McDonald, Senior Governance Manager
March 2023

North East London
Integrated Care Board

NHS North East London ICB board

29 March 2023

Title of report	Report from the Quality Safety and Improvement (QSI) committee, held on 8 February 2023 exception report
Author	Diane Jones, Chief Nursing Officer
Presented by	Imelda Redmond, Non-Executive Director
Contact for further information	Diane Jones, diane.jones11@nhs.net
Executive summary	The third meeting of the Quality Safety and Improvement (QSI) committee was held on 8 February 2023 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. • At the meeting we discussed recent ambulance industrial action and the support put on place to support residents at place such as additional GP appointments. A number of staff also spent the day at the ambulance headquarters to receive and manage emergency calls. The learning from this experience is being addressed through the daily incident management meetings. • The committee asked for feedback at the next meeting with a focus on any known / measurable impact to residents. • The committee received a report on resident access to urgent and emergency care. Whilst the pathway involves all sections of health and care, the paper focused on the discharge elements and maintaining resident wellbeing in the community. • There was also a discussion about risks when the system is under pressure and how this could be mitigated through whole system risk awareness and management. • The committee received the quality exception report, which covered: an update on the vaccination programme Safeguarding adults, children and looked after children (LAC) Quality at place Continuing healthcare (CHC) Maternity and Infection prevention and control (IPC)
Action required	The board is asked to: • Note the areas of quality improvement and quality assurance discussed by the QSI committee
Previous reporting	The topics covered in this report has previously been considered and scrutinised by the QSI committee
Next steps/ onward reporting	The board will have a wider discussion regarding urgent and emergency care

	A CHC paper will be discussed at the next audit & risk committee
Conflicts of interest	There are no known conflicts of interest
Strategic fit	The ICS aims this report aligns with are: • 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	Each topic is an area of service delivery which aims to improve the quality of care for local people through recognising opportunities for quality improvement.
Impact on finance, performance and quality	All the topics show improved performance, although in some areas the pace of progress has been slow (e.g. CHC) All the topics highlight areas for further quality improvements, particularly where joint working at place is beneficial for local delivery.
Risks	Of the topics discussed by QSI the greatest risks noted are UEC pathway, resident access to unplanned care Maternity – Delivery against the Ockenden recommendations

Quality Safety and Improvement committee exception report

1.0 Purpose of the report

1.1 This report provides the Board with an overview of the items discussed at the QSI committee held on 8 February 2023 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. There were rich discussions reflecting the strategic importance of the papers presented to the work of all partners.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The Committee discussed system risks which will help to inform the forward planning of items for discussion and or approval.

2.2 The committee received an update on the London Ambulance industrial action and ways in which the system stood up services to manage patient flows and keeping residents safe. A number of clinical staff also supported the ambulance emergency operations centre (EOC) with call handling. The experience and learning from EOC has been shared with the system and we are looking at testing other approaches to managing emergency calls

2.3 The committee had a detailed discussion about improving access to urgent and emergency care for our residents. The focus was on discharge planning and system decisions to manage risks, particularly when the system or parts of the system is under pressure.

2.4 The committee received the quality exception report, which covered:

- An update on the vaccination programme
- Safeguarding adults, children and looked after children (LAC)
- Quality at place
- Continuing healthcare (CHC)
- Maternity and
- Infection prevention and control (IPC)

3.0 Risks and Mitigations

The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

3.1 There are no additional risks arising as a result of this report.

Diane Jones 9 March 2023

NHS North East London ICB Board

29 March 2023

Title of report	Finance, Performance and Investment Committee exception report
Author	Matthew Knell, Senior Governance Manager
Presented by	Henry Black, Chief Finance and Performance Officer Kash Pandya, Associate non-executive member/ Chair of the finance, performance and investment committee
Contact for further information	matthew.knell@nhs.net
Executive position summary	The latest meeting of the Finance, Performance and Investment Committee (FPIC) was held on Monday 27 February 2023 and in addition to its examination and discussion of performance and a financial overview and delivery update on the revised forecast out-turn protocol, the Committee discussed: • The Finance and Performance risk register • An initial, first draft of the 2023/24 operating plan • NEL status against the NHS System Oversight Framework (SOF) 2022/23 • The transfer of delegated responsibility for commissioning of Pharmacy, Optometry and Dental services (PODS) from NHS England to London ICBs hosted by NEL ICS • A business case for local GP Access Hub services • The Joint Working Agreement for Specialised Commissioning • Continuing Health Care (CHC) Any Qualified Provider (AQP) / non-AQP cost uplifts for 2023/24 • An update on the Healthcare Financial Management Association (HFMA) checklist progress
Action required	The Board is asked to note the report.
Previous reporting	None – this is an exception report from the 27 February 2023 Committee meeting
Next steps/ onward reporting	The Committee meets again on Monday 27 March 2023 and a regular exception report will be presented to the Board along with any approved minutes.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	The ICS aims this report aligns with are: • To enhance productivity and value for money • To support broader social and economic development

Impact on local people, health inequalities and sustainability	One of the Committee's responsibilities is to review and approve allocation of contingency funding which is to include transformation, productivity and to aid the reduction of health inequalities for the residents of North East London.
Impact on finance, performance and quality	The Committee is established to provide assurance and oversight to the Board on the robustness of the short- and long-term financial strategy and management for the ICB. It will provide assurance to the ICB on operational performance as it relates to the Operational Planning guidance for acute and non-acute metrics, both constitutional and non-constitutional standards as appropriate.
Risks	The duties of the Committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1 The latest meeting of the Finance, Performance and Investment Committee (FPIC) took place held on Monday 27 February 2023 and this exception report outlines the key messages, recommendations, decisions and actions taken by its members in accordance with its terms of reference.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The Committee received an update on the current performance and financial position for the ICS and the ICB, which included information on Month 8 (November 2022) performance (with month 9 urgent & emergency care data) and Month 10 (January 2023) finances. The Committee discussed the impact of high demand on urgent and emergency care at the end of 2022, recognising that there were early, emerging signs that performance was improving in February 2023. The Committee considered the year end 2022/23 financial position across NEL and the need to rely on non-recurrent funding to achieve the financial target set by the NHSE for the year and its impact on financial planning for 2023/24.

2.2 The Committee was briefed on an early, initial 2023/24 Operating Plan based on the draft submission to NHS England. Members discussed the early plans, including the uplift in allocations and impacts of growth and inflation on future funding but which still leave a significant financial gap across the system that will need to be bridged. A further revision of the plan following intensive partnership working to reduce the financial gap is to be presented at the March 2023 Committee meeting for further discussion and recommendation to the Board..

2.3 The Committee discussed the due diligence that had been undertaken on the transfer of delegated responsibility for commissioning of Pharmacy, Optometry and Dental services (PODS) from NHS England to London ICBs hosted by NEL. Members recognised the support in place across the ICB and with partners and internal audit to provide assurance on the transfer process.

2.4 The Committee received and approved a business case to extend GP Access Hub contracts for up to a further 6 months at an indicative cost of £4,589,490, until 30 September 2023 and give 6 months notice at the same time to providers. This will enable the commissioning team to properly assess the future of these services in an integrated context, along with other primary care same day services. The FPIC will be kept updated on the progress of this work on a regular basis in the coming months.

2.5 The Committee received and recommended the approval of the Joint Working Agreement for Specialised Commissioning, which will proceed to the ICB for final approval. The Committee flagged that an assessment of the resource and capacity needed to support this programme of work will be vital to its success.

3.0 Risks and mitigations

3.1 The Committee received a first cut of the Finance and Performance Directorate Risk Register, containing red risks rated at 12 and above and recognised that this remained work in progress and that risks needed to be developed and documented around the 2023/24 operating plan, along with supporting material to document changes in risk on a monthly basis.

3.2 The are no additional risks arising as a result of this report.

Author: Matthew Knell, Senior Governance Manager
Date: 08/03/2023

NHS North East London ICB Board

29 March 2023

Title of report	Population health and integration committee exception report
Author	Katie McDonald, Governance Manager
Presented by	Marie Gabriel, ICS Chair/ Chair of the Population Health and Integration Committee
Contact for further information	Katie.mcdonald3@nhs.net
Executive summary	The last meeting of the population health and integration committee was held on 22 February 2023 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. This report provides an overview of the agenda items discussed and any resulting actions.
Action required	The Board is asked to note the report.
Previous reporting	None – this is an exception report from the 22 February meeting.
Next steps/ onward reporting	The committee meets again on 26 April 2023 and a regular exception report will be presented to the Board along with any approved minutes.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access
Impact on local people, health inequalities and sustainability	The remit of the committee is to identify opportunities to support and improve effective population health management and integration of health and care services at place and within collaboratives for the residents of north east London.
Impact on finance, performance and quality	N/A
Risks	The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1 The Population Health and Integration Committee was held on 22 February 2023 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. There were rich discussions reflecting the strategic importance of the papers presented to the work of all partners.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The Population Health and Integration Committee (the Committee) met on 22 February 2023. The first item on the agenda was a proposal for £6.6m health inequalities funding for three years from April 2023, based on learning from the 2022/23 funding process. The committee supported the three-year commitment and requested further information regarding the data sets being used to inform the allocation formula to ensure that they are reflective of experience and up to date. The committee requested a further update at its next meeting to review the allocation formula and recommended that evaluations of the projects and schemes using the health inequalities fund should be presented to the committee on a quarterly basis.

2.2 The committee received an update report on the Big Conversation events that are due to be held in the spring which will stretch and enhance the participation and voice of local people, using a range of methods. A programme of events to deliver stimulating and productive activities, which are theme focused and delivered at Place are being planned and the outcomes of these activities can be brought together to support our continued focus on equity and prevention. The committee thought it would be beneficial to create a wider programme of Big Conversation events which also contain some smaller, targeted groups with residents that have lived experience of particular issues to ensure the voices of all communities are captured in discussions.

2.3 The committee received a presentation from representatives of the Waltham Forest Place Partnership which highlighted how the partnership is interfacing with the system to develop population health management with a public health approach. The committee welcomed the presentation and requested that an agenda item is scheduled for a future meeting to discuss how the Marmot approach could inform health inequalities work across the system, and noted the importance of places developing their own models to reflect the different needs of their populations.

2.4 The final set of reports presented to the committee were a series of updates from the place and provider collaborative sub-committees which explained the work that is being done to improve population health, how the sub-committees are enabling integration and the progress made with working together with local people and communities. Several common themes were identified throughout the reports so members suggested that, going forward, it would be beneficial to receive an update which identifies cross cutting themes across the places and collaboratives. This approach will enable the committee to identify commonalities which can be improved upon, whilst considering whether demonstrations of best practice can be scaled up across north east London.

3.0 Risks and mitigations

3.1 The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

3.2 There are no additional risks arising as a result of this report.

Author: Katie McDonald, Governance Manager
Date: 03.03.2023