North East London
Integrated Care Board

# Havering ICB Sub-Committee
# Agenda
**10 May 2023**
**4.30pm – 5.10pm Via MS Teams**

| | Item | Time | Lead | Attached/ verbal | Action required |
|---|---|---|---|---|---|
| **1.0**<br>**1.1** | **Welcome**<br>Declarations of Interest | 4.30<br>(5 mins) | Chair | Verbal | |
| **2.0** | Questions from the Public | 4.35<br>(10 mins) | Chair | Verbal | Discuss/ note |
| **3.0** | Operating Plan | 4.45<br>(15 mins) | Saem Ahmed | Attached<br>*Pages* | Approve |
| **4.0** | Better Care Fund | 5.00<br>(10 mins) | Pete McDonnell | Verbal | Note |
| **5.0** | Any other business | 5.10 | All | Verbal | Discuss/ Note |
| **Date of next meeting:**<br>**12 July 2023 – Partnership Board/ICB Sub-Committee** | | | | | |

NHS North East London

- Declared Interests as at 03/05/2023

| 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<br>Havering Partnership Board<br>ICB Board<br>ICB Workforce & Remuneration Committee<br>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 |
| Barbara Nicholls | Director of Adult Social Care & Health, Havering Council | Havering ICB Sub-committee<br>Havering Partnership Board | Non-Financial Professional Interest | Association of Directors of Adult Social Services (ADASS) | Professional membership | 2016-01-01 | | Declarations to be made at the beginning of meetings |
| Brid Johnson | Member of sub-committee | Barking & Dagenham ICB Sub-committee<br>Barking & Dagenham Partnership Board<br>Havering ICB Sub-committee<br>Havering Partnership Board<br>Redbridge ICB Sub-committee<br>Redbridge Partnership Board<br>Waltham Forest Health and Care Partnership Board<br>Waltham Forest ICB Sub-committee | Indirect Interest | Mid and South Essex ICB | My Partner is a Non-Executive Director at MSE ICB | 2022-08-25 | | |
| Chetan Vyas | Director of Quality | Barking & Dagenham ICB Sub-committee<br>Barking & Dagenham Partnership Board<br>City & Hackney ICB Sub-committee<br>City & Hackney Partnership Board<br>Havering ICB Sub-committee<br>Havering Partnership Board<br>ICB Population, Health & Integration Committee<br>ICB Quality, Safety & Improvement Committee<br>Newham Health and Care Partnership<br>Newham ICB Sub-committee<br>Redbridge ICB Sub-committee<br>Redbridge Partnership Board<br>Tower Hamlets ICB Sub-committee<br>Tower Hamlets Together Board<br>Waltham Forest Health and Care Partnership Board<br>Waltham Forest ICB Sub-committee | Indirect Interest | North East London CCG | Spouse is an employee of the CCG | 2014-04-01 | | Declarations to be made at the beginning of meetings |
| | | | Indirect Interest | Some GP practices across NEL | Family members are registered patients - all practices not | 2014-04-01 | | Declarations to be made at the beginning of meetings |

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| | | | | | known nor are their registration dates | | | |
| | | | Indirect Interest | Redbridge Gujarati Welfare Association - registered charity in London Borough of Redbridge | Family member is a Committee member. | 2014-04-01 | | Declarations to be made at the beginning of meetings |
| Emily Plane | Programme Lead - BHR System Development | Barking & Dagenham ICB Sub-committee<br>Barking & Dagenham Partnership Board<br>Havering ICB Sub-committee<br>Havering Partnership Board<br>Redbridge ICB Sub-committee<br>Redbridge Partnership Board | Non-Financial Personal Interest | The Greenwood Practice | I am a regisered paien of he Greenwood GP Pracice, Gubbins Lane, Harold Wood, in Havering. | 2022-04-01 | 2022-11-01 | |
| | | | Non-Financial Professional Interest | Petersfield Surgery | I am a registered patient of Petersfield Surgery in Havering. | 2022-11-02 | | |
| John Timbs | Director Care Provider's Voice | Havering ICB Sub-committee<br>Havering Partnership Board | Financial Interest | Lodge Group Care Uk Ltd | Managing Director | 2008-01-01 | | |
| | | | Non-Financial Professional Interest | Havering Care Association/Care Provider's Voice | Director | 2018-09-03 | | |
| Michael Armstrong | Co-Chair Care Providers Voice | Havering ICB Sub-committee<br>Havering Partnership Board | Financial Interest | Havering Care Homes | Director of Havering Care Homes | 2014-01-03 | | |
| | | | Non-Financial Professional Interest | Havering Care Association/ CPV | Non exec Director | 2018-11-01 | | |
| Narinderjit Kullar | Clinical Director, Havering Place Based Partnership | Clinical Advisory Group<br>Formulary & Pathways Group (FPG)<br>Havering ICB Sub-committee<br>Havering Partnership Board | Financial Interest | St Edwards Medical Centre | GP Partner at practice | 2017-11-01 | | |
| | | | Non-Financial Personal Interest | BHRUT | Wife works within the trust (Quality and Safety) | 2017-11-01 | | |
| | | | Non-Financial Personal Interest | Havering Health GP Federation | Wife's Brother-in-Law is employed by the GP Federation | 2016-12-01 | | |

- Nil Interests Declared as of 03/05/2023

| Name | Position/Relationship with ICB | Committees | Declared Interest |
|---|---|---|---|
| Selina Douglas | Executive Director of Partnerships | Barking & Dagenham ICB Sub-committee<br>Barking & Dagenham Partnership Board<br>Havering ICB Sub-committee<br>Havering Partnership Board<br>Mental Health, Learning Disability & Autism | Indicated No Conflicts To Declare. |

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| | | Collaborative sub-committee<br>Redbridge ICB Sub-committee<br>Redbridge Partnership Board<br>Waltham Forest Health and Care Partnership Board<br>Waltham Forest ICB Sub-committee | |
| Charlotte Pomery | Chief Participation and Place Officer | Barking & Dagenham ICB Sub-committee<br>Barking & Dagenham Partnership Board<br>City & Hackney ICB Sub-committee<br>City & Hackney Partnership Board<br>Havering ICB Sub-committee<br>Havering Partnership Board<br>ICB Board<br>ICB Population, Health & Integration Committee<br>ICB Quality, Safety & Improvement Committee<br>ICP Committee<br>ICS Executive Committee<br>Newham Health and Care Partnership<br>Newham ICB Sub-committee | Indicated No Conflicts To Declare. |
| Mark Ansell | member of a committee | Clinical Advisory Group<br>Havering ICB Sub-committee<br>Havering Partnership Board | Indicated No Conflicts To Declare. |
| Annette Kinsella | Member of Committies/working groups | Havering ICB Sub-committee<br>Havering Partnership Board | Indicated No Conflicts To Declare. |
| irvine muronzi | Intergrated Care Director | Havering ICB Sub-committee<br>Havering Partnership Board | Indicated No Conflicts To Declare. |
| Manahil Khan | Transformation Lead / Covid-19 Site Lead / Leading on Health Inequalities Projects | Havering ICB Sub-committee<br>Havering Partnership Board<br>ICB Finance, Performance & Investment Committee | Indicated No Conflicts To Declare. |
| Ben Molyneux | Primary Care Development Lead | Havering ICB Sub-committee<br>Havering Partnership Board<br>Primary Care Collaborative sub-committee | Indicated No Conflicts To Declare. |

North East London Health & Care Partnership

## Havering Integrated Care Board Sub Committee

10th May April 2023

| Title of report | 23/24 Operating Plan Final Submission |
| --- | --- |
| **Author** | Saem Ahmed – Head of planning and performance<br>Dion Davies – Deputy director of finance |
| **Presented by** | Saem Ahmed – Head of planning and performance<br>Sunil Thakker – Director of finance |
| Executive summary | • 4 key priorities set out in the 23/24 planning guidance<br>1. Recovering core services and productivity<br>2. Delivering LTP ambitions<br>3. Transforming the NHS<br>4. Local empowerment and accountability<br>• There are a range of national objectives and key targets set by NHS England on slide 3.<br>• Although the 5 year cycle of the LTP has expired, the guidance makes a commitment to continue with the community health services LTP commitments across 23/24.<br>• We have submitted complaint trajectories for most of the key areas where targets were set, however with a few exceptions mainly in mental health.<br>• While we have submitted compliant trajectories in some areas there is a risk of deliverability.<br>• NEL allocation for 23/24 of £4.18bn (excluding running costs)<br>• ICB plan submission will be break even, however Includes high degree of specific risk around inflationary pressures of c.£20m in prescribing and CHC to be managed through NR measures and /or benefits from inflation falling quicker than anticipated. £88m of efficiencies assumed to be delivered with ongoing review opportunities to reduce expenditure. |
| **Action required** | Note |
| **Previous reporting / discussion** | • NEL FPIC |
| **Next steps / onward reporting** | • ICB Board |
| **Conflicts of interest** | N/A |
| **Strategic fit** | • To improve outcomes in population health and healthcare |

| | |
|---|---|
| | • To tackle inequalities in outcomes, experience and access<br>• To enhance productivity and value for money |
| **Impact on local people, health inequalities and sustainability** | Acute provider collaborative leads are currently developing their inequalities plans, which identify how they will continue to take specific, targeted action to address inequalities in access, experience and outcomes – such as reviewing equity in waiting lists, exploring which patients choose to decline critical care, or characteristics of patients with cancer undertaking clinical trials. Place Partnerships have continued to focus on addressing health inequalities in all that they do – engaging with a diverse range of local people and communities, building community outreach models to enable and improve vaccination take up, recognising the strength of a localities and neighbourhood approach to addressing need early as a few examples. Our North East London ICS Financial Strategy also demonstrates our commitment to addressing health inequalities through its focus on sustainable approaches to levelling up and reducing gaps across our geography. |
| **Impact on finance, performance and quality** | The activity and performance trajectories need to triangulate with finance and workforce. |
| **Risks** | • High degree of specific risk around inflationary pressures of c.£20m in prescribing and CHC to be managed through NR measures and /or benefits from inflation falling quicker than anticipated. £88m of efficiencies assumed to be delivered with ongoing review opportunities to reduce expenditure.<br>• In some areas performance currently is significantly lower than the expected targets and therefore deliverability will be challenging.<br>• Non-compliant trajectories for mental health. |

North East London

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# Planning submission- - Round 3

Saem Ahmed – Head of planning and performance

# Background

- NHSE have re-opened the planning round after our final submission in March.
- Systems **must seek to live within the funding Parliament has made available to us**, and accordingly individual NHS bodies have legal responsibilities to seek to live within the resources allocated to them by NHS England.
- In some cases, the plans demonstrate a credible path to delivery, **but many still show a significant gap**, particularly in terms of financial balance.
- Along with finances **the activity, performance and workforce has also re-opened** allowing systems to update trajectories if required.
- A **short form business case** process is issued for the additional UEC capital schemes.
- Final plans must be signed off by ICB and partner trust and foundation trust boards.
- The deadline set by NHSE is the **4th May 2023.**

# Re-opened plans

**Activity and performance**

- The NHSE operational planning - activity and performance data collection portal is now open.
- The version of the template has been incremented to v26.1.This has been done to address an issue with historical data that affected NHS NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD.
- Updates to final submission (if required) for either the activity or performance trajectories.

**Workforce**

- The workforce planning eCollection portal open). The data from the second submission (30th March) has been retained in the eCollection portal.

Provider workforce plans:

- WTE (all 5 years)
- Supply bridge
- Hosted
- KPI's
- Mental Health (Mental Health providers only)

ICB workforce plans:

- Primary Care
- Non-NHS Mental Health
- Non-Mental Health Trusts

# UEC capital schemes: additional capacity targeted investment fund

- There is a short form business case plus annexes for schemes >£5m and a separate Programme of Works template for schemes between £2m-£5m. Please note that schemes below £2m capital are not supported so these will need to drop out.

- This process is **not for revenue schemes**, ONLY for capital schemes. **Any schemes below £2m will drop off** – therefore it is suggested to combine schemes that achieve to achieve £2m threshold.

- **Business cases MUST be signed off by Trust board**, and **supported by a letter from the ICB** endorsing the business case.

- **NHSE monthly reporting on progress** of delivery once business case is approved.

- The critical bit of this is that your **schemes are deliverable** and the following are the key tests we will be applying:

    1. The scheme is fully deliverable in 2023/24 and that this assessment is supported by the Trust, ICB and regional teams (including regional estates colleagues).
    2. The timeline outlined in the SFBC/POW should be clear and linked to trajectories submitted in plans in terms of capacity/performance impact.
    3. The assessment of when the scheme can/will be delivered by should be clear and as specific as possible.
    4. The national estates team will shortly issue a note to Regional estates leads outlining the support available from them and the work that they have done to generate support and interest from the P23 framework and principal supply chain partners (PSCPs) to support delivery of schemes – where the P23 framework/PSCPs are not proposed to be used please ensure the SFBC/POW is clear on the rationale for the procurement route and assessment of deliverability of the scheme.
    5. Costs outlined in the SFBC/POW need to be genuine assessed costs and not wholly indicative.
    6. Specific attention is provided to the ownership of land/property section so that risks and considerations relating to PFI sites, NHSP sites, and sites subject to lease arrangements or purchase are outlined in full.
    7. Specific attention is provided to the overall financial case – including the workforce requirements for the scheme, as well as the link back to the revenue implications of the scheme and how these will be funded either from core allocations or proposed investment submitted via the 23/24 planning round.

# NEL & London timelines

**28th April**

- Short form business case – **NHS LONDON DEADLINE**

**2nd May**

- Activity and workforce plans
- Workforce plans

**4th May**

- Final submission to NHSE

**No further opportunity if this deadline is not met!**

North East London

# 23/24 Operating plan

Final submission summary – place partnerships

# 23/24 NHS priorities

## Recovering our core services and productivity

- Improve ambulance and A&E waiting times
- Reduce elective long waits and cancer backlogs, and improve performance against core diagnostic standards
- Make it easier for people to access primary care services, particularly in general practice

## Delivering the key NHS Long Term Plan ambitions and transforming the NHS

## Continue transforming the NHS for the future

- Improve mental health services and services for people with a learning disability and autistic people
- Prevention and the effective management of long-term conditions are key to improving population health and curbing the ever increasing demand for healthcare services
- We need to put the workforce on a sustainable footing for the long term
- To level up digital infrastructure and drive greater connectivity

## Local empowerment and accountability

- ICSs are best placed to understand population needs and are expected to agree specific **local objectives that complement the national NHS objectives**
- They should continue to pay due regard to wider NHS ambitions in determining their local objectives – alongside place-based collaboratives

# 2023/24 national objectives and key targets

**Urgent and emergency care**
- Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
- Reduce adult general and acute (G&A) bed occupancy to 92% or below

**Community health services**
- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
- Virtual Ward – 40 – 50 per 100,000 by December 2023, and occupancy at 80% by September 2023
- Community waiting list reduction
- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals

**Primary Care**
- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
- Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic level

**Elective care**
- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
- Deliver the system- specific activity target (agreed through the operational planning process)
- Value weighted elective activity target (as a % of 2019/20)–excludes secondary dental 109%
- Reduce outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024
- To increase productivity and meet the 85% day case and 85% theatre utilisation expectations

**Cancer**
- Continue to reduce the number of patients waiting over 62 days
- Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028

**Diagnostics**
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition

**Maternity**
- Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
- Increase fill rates against funded establishment for maternity staff

**Mental Health**
- Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
- Increase the number of adults and older adults accessing IAPT treatment
- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
- Work towards eliminating inappropriate adult acute out of area placements
- Recover the dementia diagnosis rate to 66.7%
- Improve access to perinatal mental health services

**Use of resources**
- Deliver a balanced net system financial position for 2023/24

**People with a learning disability and autistic people**
- Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
- Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit

**Prevention and health inequalities**
- Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
- Continue to address health inequalities and deliver on the Core20PLUS5 approach

**Workforce**
- Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise

# Ongoing CHS LTP priority commitments across 2023/24

Putting people in control of their own care through more personalisation

**(Government Mandate to the NHS, 22/23)**

Growth and development of integrated neighbourhood teams to support our most vulnerable and complex patients to stay at home and access care in the community

**(Fuller Stocktake)**

Deliver an additional 2,500 Virtual Ward (VW) beds, effectively utilised both in terms of addressing the right patient cohort and optimising referrals.

**(NHS Winter Letter)**

Actively consider establishing an Acute Respiratory Infection (ARI) hub to support same day assessment

**(NHS Winter Letter)**

Putting in place a community-based falls response service in all systems for people i.e. who have fallen at home including care homes

**(NHS Winter Letter)**

Ensuring that patients receive personalised care tailored to their individual needs

**(NHS Standard Contract 22/23)**

Comply with the new statutory duty for ICBs to commission palliative and end of life care services in response to population needs, drawing upon NHSE statutory guidance.

**(Palliative and end of life care: Statutory guidance for integrated care boards (ICBs)**

Shift more care to the community, including safe and convenient care at home or close to home, through developing the capacity and capability of community health services, integrated neighbourhood teams and new models of care

**(NHS England operating framework)**

Strengthen the hands of the people we serve through the comprehensive model of personalised care including supporting people to have increased choice and control over their care based on what matters to them as well

**(NHS England operating framework)**

# 2023/24 national objectives and key targets

| Area | 23/24 Key Target | 23/24 plan compliance |
|---|---|---|
| Urgent and emergency care | 1. Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25<br>2. Reduce adult general and acute (G&A) bed occupancy to 92% or below | 1. Meets target<br>2. Meets target |
| Elective care & Diagnostics | 1. Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)<br>2. NELs overall elective activity (EL + DC + Total Outpatient First) trajectory is 106.5% compared to 2019/20, Barts trajectory is 106.2%, Homerton trajectory is 100.5% and BHRUT trajectory is 109.6%.<br>3. Reduce outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024<br>4. Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% | 1. Meets target<br>2. Meets target<br>3. Not compliant<br>4. Meets target |
| Cancer | 1. Continue to reduce the number of patients waiting over 62 days<br>2. Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days<br>3. Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 | 1. Meets target<br>2. Meets target<br>3. Meet target |
| Community health services | 1. Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard<br>2. Virtual Ward – 40 – 50 per 100,000 by December 2023, and occupancy at 80% by September 2023 | 1. Meets target<br>2. Partially meet target (deliver 40 per 100,000 in March) |
| Primary Care | 1. Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic level | 1. Not compliant |
| Mental Health | 1. Inappropriate Out of Area Placement Bed Days<br>2. Access to IAPT Services<br>3. Estimated dementia diagnosis rate<br>4. Women accessing Perinatal Mental Health services<br>5. Community access for adults with SMI<br>6. Access to CYP services | 1. Meets target<br>2. Not compliant<br>3. Meets target<br>4. Not compliant<br>5. Meets target<br>6. Not compliant |
| People with a learning disability and autistic people | 1. Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024<br>2. Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit | 1. Meets target<br>2. Meets target |

# Executive summary 1/2

**Elective and diagnostics**
- 109% ERF achieved.
- Homerton Healthcare expected to clear all waits over 65 weeks by end of July 2023
- Barts Health and BHRUT expect to clear all waits over 65 weeks end of March 2024
- Activity levels in our diagnostic modalities exceed 100% of BAU, and our 23/24 plans will continue to sustain this, with the exception of endoscopy where we have successfully recovered the waiting list position and demand has reduced.

**Cancer**
- NEL is required to achieve a backlog of below 7% in aggregate (patients waiting over 62 days by March 2024), currently the backlog is 7.4%. NEL have submitted a trajectory that will meet the target through target pathway approach and enhancing validation of long waiters.
- NEL have submitted a compliant trajectory against 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days through utilisation, and expansion of early diagnostic centres, improving referrals for FIT testing, Teledermatology will continue in Barts Health and BHRUT.
- NEL have submitted compliant trajectories for early diagnosis through prevention awareness and screening ( key programmes include targeted lung health check, targeted awareness and focusing on key demographics and hard to reach groups; with a specific focus on reducing inequality). Additional initiatives spans across our diagnosis and treatment workstream to ensure timely access and treatment including via non-traditional pathways such as piloting self and pharmacy direct referrals.

**Urgent and emergency care**
- All our Trust have submitted compliant trajectories to deliver 76% standard by March 2024. Homerton is the only Trust that is currently compliant and therefore will be a stretching target to achieve for Barts Health and BHRUT particularly. There are various schemes around admitted and non-admitted pathways across our sites to support delivery of this target.
- Additional capacity funding has been approved by NHSE which build additional bed capacity in our hospitals to support delivery of the bed occupancy and A&E targets.

**Community services**
- NEL continue to submit to deliver on the 70% UCR contacts within 2 hours and have sustained this performance in 23/24 trajectories. Further work is being undertaken to increase referrals through UCR to support with front door pressures.
- Virtual Ward currently at 23 bed per 100,000. The trajectory for 23/24 is 30 beds from April to December and deliver the target of 40 by March 2024. This will be a stretching target, however a key area of focus for the community collaborative.
- There are not targets set for community waiting lists, however the main concern for NEL is Children Services as 54% seen within 18 weeks with 46% seen over 18 weeks. The community collaborative agreed that speech and language is an area of focus and deep dive which is the driver of the longest waits.

# Executive summary 2/2

**Primary Care**

- NEL GP appointments will increase by an average of 3% in 23/24 compared to 22/23. GP Appointment numbers have been derived by looking at the borough level population increase projections and then applying these to appointment activity data (for 2022), patient turnover will remain at a similar level which is as high as 30% churn in some neighbourhoods. Although we have not set targets for each place we will provide continued support will be given to local systems to understand variation and inequalities through reviewing performance including data and coding at a practice level. This will inform development of local pathways in and out of primary and urgent care to scope the needs of local patient cohorts.
- The recovery plan for Dentistry is iterative on the basis that many of the issues that affect access to dentistry are centred around the current contract and we have no ability to amend or flex this. That said, one aspect is the ability to allow practices to overperform up to 110% where capacity allows and remunerate them accordingly. Practices are contractually obliged to achieve 96% of their contracted activity to avoid the resource associated with underperformance being ‘clawed back.

**Mental Health and Learning Disability**

- IAPT and perinatal mental health non-compliant trajectory - Unable at this point to commit sufficient financial resources to achieve full compliance given UEC pathway pressures.
- CYP - CYP Urgent Care expansion is not predicted to increase access, some places need to expand duration of treatment to meet rising acuity, however this will not increase access.

**Finance**

- NEL system finance plan to be submitted at a deficit of £73.4m. The three acute providers making up the deficit will likely be subject to SoF4 interventions
- The plan excludes a significant level of risk at £80m that is currently unmitigated
- Capital plan will be financially compliant, however, the level of funding is not sufficient to meet all NELs needs and will be working with London to seek additional funding in year.

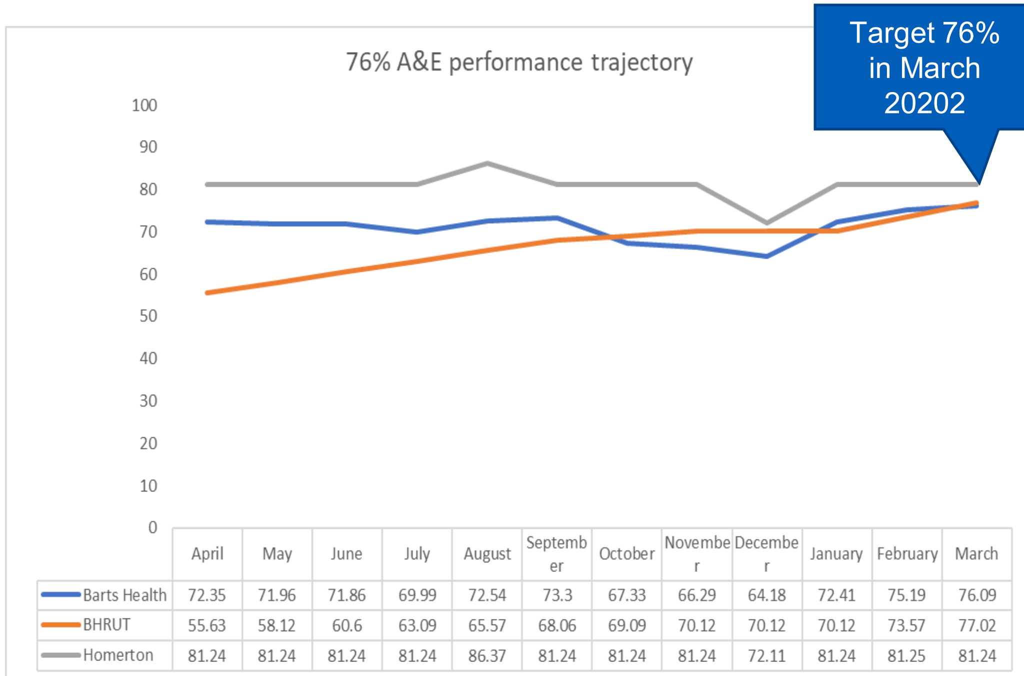
# 23/24 NEL ICB Elective Summary from Final Op Plan Submission

| Area / Metric | Objective / Target | Position as per Final Submission |
|---|---|---|
| Inpatients - Long Waiters Elimination / Reduction | Eliminate waits of over 65 weeks for elective care by March 2024 | ● All Trusts are expecting to deliver the 65 week wait time reduction requirements for 23/24. |
| | Reduce 52 ww | ● All Trusts are showing a trajectory that reduces 52ww across the year. |
| Activity Increase | Delivery of around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance | ● NELs overall elective activity (EL + DC + Total Outpatient First) trajectory is 106.5% compared to 2019/20, Barts trajectory is 106.2%, Homerton trajectory is 100.5% and BHRUT trajectory is 109.6%. |
| Outpatient Follow-Up Reduction | Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024 | ● 25% reduction in outpatient follow-up will not be achieved across all follow-up activity given size of backlog and impact of mutual aid, NEL trajectory is 103% compared to 2019/20. Barts Health are the only trust with a trajectory over 100% compared to 2019/20 at 106%, the Trust has revised the position down from 117% in the draft submission. BHRUT trajectory is 97% and Homerton Trajectory is 99%. |
| PIFU / A&G | ** No specific ask in guidance ** | PIFU and A&G trajectories build on performance seen in 2022/23, however room for improvement. |
| Productivity - Theatre Utilisation & Daycase | Increase productivity and meet the 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings | ● The system is on track and planning to achieve the 85% theatre utilisation target with plans to improve waste through reducing late starts, early finishes, cancellations and fallow sessions. |
| | Increase productivity and meet the 85% day case expectations, using GIRFT and moving procedures to the most appropriate settings. | ● The system is on track and planning to increase daycase rates to the 85% target. |
| Diagnostics - Activity Increase & 6ww | Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition | ● Increased diagnostic activity compared to 2019/20 will not be achieved in endoscopy given success in clearing the backlog and current levels of demand. Activity is over at or 100% for all modalities, except flexi sigmoidoscopy which is 60.6%. |
| | Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% | ● NEL appears to be on track to achieve 95% 6 week diagnostic test ambition by March 2025, with MRI being the only real risk. |

# Cancer

| Question | Response |
|---|---|
| **How will your system reduce the number of patients waiting over 62 days in line with the provider level requirements?**<br><br>**23/24 meets target** | • NEL is required to achieve a backlog of below 7% in aggregate (patients waiting over 62 days by March 2024). Currently the backlog is 7.4%.<br>• Targeted pathway approach in urology (access to MRI & TP biopsy), H&N (outpatient capacity and ENT calculator), LGI (appropriate escalation of pathology turnaround times and endoscopy capacity), Skin ( tele-dermatology with one stop excision following triage).<br>• Ongoing weekly APG meetings with providers, Cancer Alliance, ICB supported by the Centre for Cancer Outcomes (CCO).<br>• Administrative support- developing a central operational project support for MDT with flexibility to support more challenged tumour areas when required by the system. The team will additionally support validation.<br>• Enhancing validation resource, working with the independent sector and system wide solutions (including working with other programmes and networks such as Elective and diagnostic programmes) are some of the mechanisms that will be used.<br>• Enhancing our visibility- Development of a single North East London Cancer digital PTL. |
| **How will your system meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days?**<br><br>**23/24 meets target** | • The system will continue to utilise the Early and community Diagnostic Centre and will expand the capacity across other modalities to meet expected levels of growth.<br>• Expansion of the diagnostic capacity through the CDC programme.<br>• The system will maintain the pathway changes for lower GI to include (referrals with a FIT test).<br>• The use of teledermatology will continue at BHR and BH with the support of the Cancer Alliance. Whilst the system explores the use of AI technologies to further manage the demand challenges on the skin pathway. Insourcing at Homerton solutions will be used to facilitate the management of demand at HUH.<br>• The Cancer Alliance will continue working with providers to implement and strengthen best practice times pathway. With a focus on those performing below the England FDS |
| **How will your system increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028?**<br><br>**23/24 meets target** | The current proportion of cancer stage 1 and stage 2 at diagnosis is 55%. This is linked to socio- economic determinants of health in North East London. Therefore the scale of the challenge to achieve 75% is significant for North East London.<br><br>There is multi pronged approach to increase the proportion of stage 1 and stage 2 cancers. This encompasses prevention awareness and screening ( key programmes include targeted lung health check, targeted awareness and focusing on key demographics and hard to reach groups; with a specific focus on reducing inequality). Additional initiatives spans across our diagnosis and treatment workstream to ensure timely access and treatment including via non traditional pathways such as piloting self and pharmacy direct referrals. We are also expanding our RDC non site specific pathways in addition to ensuring rapid and direct access to diagnostics for primary care to our CDCs/EDC. |

# Urgent and emergency care - A&E




| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Barts Health | 72.35 | 71.96 | 71.86 | 69.99 | 72.54 | 73.3 | 67.33 | 66.29 | 64.18 | 72.41 | 75.19 | 76.09 |
| BHRUT | 55.63 | 58.12 | 60.6 | 63.09 | 65.57 | 68.06 | 69.09 | 70.12 | 70.12 | 70.12 | 73.57 | 77.02 |
| Homerton | 81.24 | 81.24 | 81.24 | 81.24 | 86.37 | 81.24 | 81.24 | 81.24 | 72.11 | 81.24 | 81.25 | 81.24 |

It is recognised that achievement of the 76% performance standard is ambitious and that there is currently variation in performance among the Acute Provider Collaborative sites. Plans have been developed to achieve this requirement with initiatives being undertaken including:-

**BHRUT**

Overall BHRUT expects a reduction in total time for time spent in A&E due to the below points:

- **Non-admitted** Expanding SDEC footprint at Queens ED & KGH will improve Type 1 performance through progressing patients quickly through RAFT and onto SDEC pathway
- **Non-admitted** Redesign of UTC to ED Pathways at KGH, following Queens ED approach, will ensure only patients meeting ED right to reside criteria are referred to ED with direct route to SDEC
- **Admitted** Clinical productivity review aligned to clinical workforce rightsizing ensure that clinical hours are matched to demand and metrics set on number of patients to be seen by hour

**Barts Health**

- Further development of our SDEC capacity and operating models across the 3 sites to improve the use of ambulatory and same day emergency care pathways
- Sustain our REACH programme, review the streaming and Urgent Treatment Centre models and develop same day primary care access hubs
- Each site within Barts Health has a High Intensity user services
- Launch of Frailty and Respiratory Virtual Wards

**Mental Health**

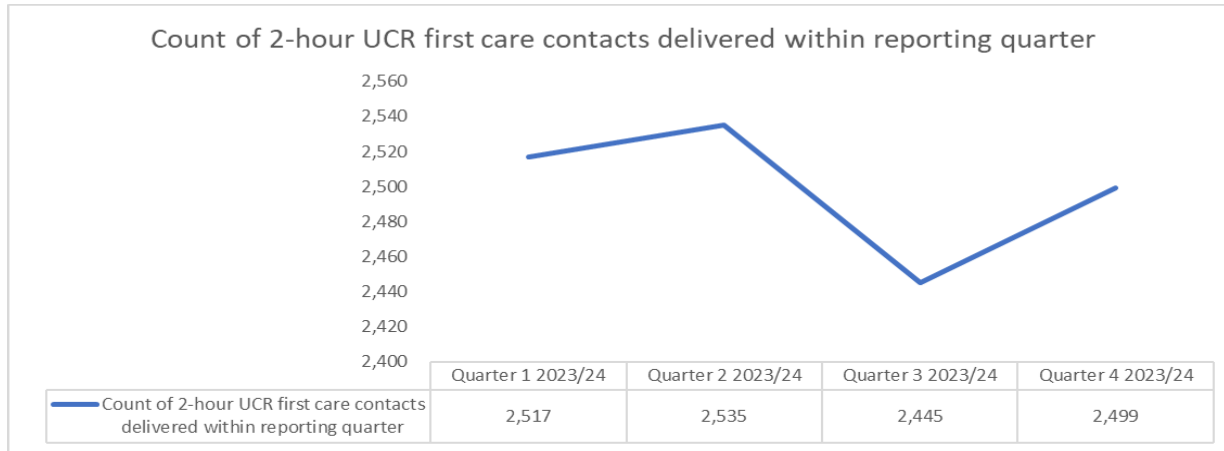
- Optimising flow through NEL inpatient services and improve availability of beds, thus reducing A&E breaches
- Improving the liaison offer available within A&Es, and responsiveness for assessment
- Increasing CDU capacity

# Urgent and emergency care – additional capacity

Additional funding was made available nationally above and beyond ICB allocations, London has £47.2m in 23/24 to invest in additional G&A bed capacity to address the UEC challenge in London. North East London received the following:

| Site - where relevant | Narrative | Increase in beds | Capital | Cost 2023/24 | Full year recurrent cost |
|---|---|---|---|---|---|
| King George Hospital | Enhanced SDEC / safe area for mental health patients awaiting onward transfer (16 beds/spaces) | 16 | £2,000 | £ 375 | £ 1,500 |
| Queens Hospital 1 | Surgical assessment unit (12 trolley spaces) | 12 | £3,000 | £ 498 | £ 1,000 |
| Queens Hospital 2 | Revenue support to optimise use of 12 bed Ambulance offload Modular Unit | 12 | £0 | £ 996 | £ 1,000 |
| Homerton Hospital 1 | Defoe Ward: continued winter scheme to ensure safe staffing levels are maintained on Defoe (escalation ward) whilst it remains open for the foreseeable. | | | £ 966 | £ 1,933 |
| Barts Health | 62 G&A beds across Barts Health sites | 62 | £554 | £ 3,000 | £ 3,000 |
| Whipps Cross Hospital | This is the setting up of a 10 chaired/bedded surgical SDEC model to avoid up to 12 admissions per day (20 admission x 60% success) | 10 | £1,550 | £ 12 | £ 12 |
| **Total** | | **112** | **£7,104** | **£ 5,847** | **£ 8,445** |

# Urgent community response




| | Quarter 1 2023/24 | Quarter 2 2023/24 | Quarter 3 2023/24 | Quarter 4 2023/24 |
|---|---|---|---|---|
| Count of 2-hour UCR first care contacts delivered within reporting quarter | 2,517 | 2,535 | 2,445 | 2,499 |

**Further opportunities:**

- A pilot was undertaken between LAS and NHS NEL to increase referrals from 111 and 999 through a push model with dedicated staff within the LAS call centres to increase referrals to our UCR services; this pilot did increase 111 and 999 referrals. The NEL Community Collaborative leaders oversee the review of learning from our pilot and from elsewhere in London to ensure our UCR models are optimal for NEL. Our next pilot will aim to both increase 111 and 999 referrals and help us to understand our local flows and potential for increasing referrals through this pathway.

- The Community collaborative is exploring the impact of delivering more than the national expectation of 70% contacts in 2 hours.

- Also exploring increasing referrals to UCR to support the wider system and A&E and unplanned admissions.

NHS NEL constantly meets and exceeds the 2-hour response time, the service is open 7 days a week across the core hours of 8am to 8pm covering the 9 core clinical conditions. Across NHS NEL the following is in place for UCR:

- The services consistently meet and exceeds the 2-hour response time and the services are open 7 days a week across the core hours of 8am to 8pm.

- The services meet the 9 core clinical conditions, as well as a wider range, this includes falls which are integrated.

- Existing pathways are in place with telecare (pendant alarm for example), 111, London Ambulance and other health teams such as A&E.

- Single points of access are in place.

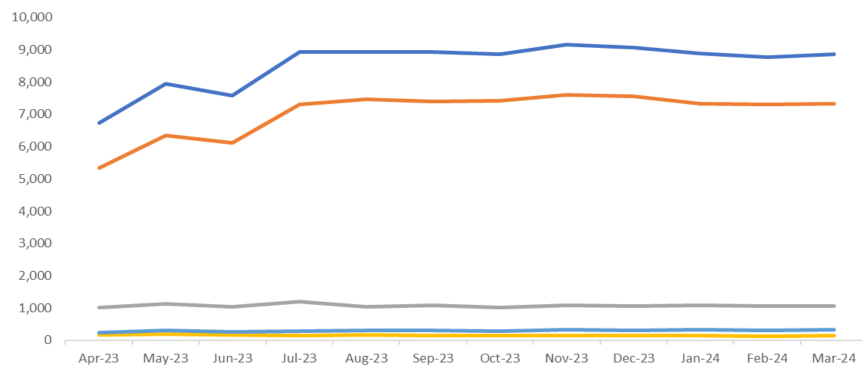
- As with every winter services are reviewed and supported to ensure that it has sufficient capacity in place for changes in demand.

- NEL UCR services have a well-established self-referral pathway, which is well known to patients already under community health services and we have a direct pathway with Primary Care teams with further work happening to increase self-referrals where variation exists currently.

- A pathway with the Remote Emergency Access Coordination Hub (REACH) is in operation in Tower Hamlets, Newham and Waltham Forest which is a joint service between Bart's Health and London Ambulance.

- LAS and NELFT have jointly operated a UCR car across Barking and Dagenham, Havering and Redbridge since 2016 and the model has been expanded to two cars in Q4 2022/23 using LAS winter funding.

# Discharge pathway




| | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| The number of people discharged by location and discharge pathway per month | 6,732 | 7,952 | 7,572 | 8,938 | 8,940 | 8,926 | 8,859 | 9,163 | 9,076 | 8,885 | 8,780 | 8,857 |
| Hospital discharge pathway activity - pathway 0 | 5,340 | 6,343 | 6,122 | 7,315 | 7,463 | 7,402 | 7,411 | 7,614 | 7,557 | 7,323 | 7,302 | 7,323 |
| Hospital discharge pathway activity - pathway 1 | 1,004 | 1,118 | 1,034 | 1,195 | 1,027 | 1,083 | 1,015 | 1,082 | 1,063 | 1,089 | 1,049 | 1,060 |
| Hospital discharge pathway activity - pathway 2 | 156 | 187 | 160 | 146 | 155 | 145 | 143 | 143 | 150 | 145 | 121 | 145 |
| Hospital discharge pathway activity - pathway 3 | 231 | 303 | 256 | 282 | 294 | 296 | 289 | 324 | 305 | 328 | 308 | 329 |

As a system NEL perform well in discharge; we have seen 9-11% of beds taken up by patients that do not meet the criteria to reside, against 15% nationally.

Some of our challenges have been:

- Capacity in more complex step down services and more complex reablement packages
- High levels of pressure on the urgent care system that put pressure on discharge

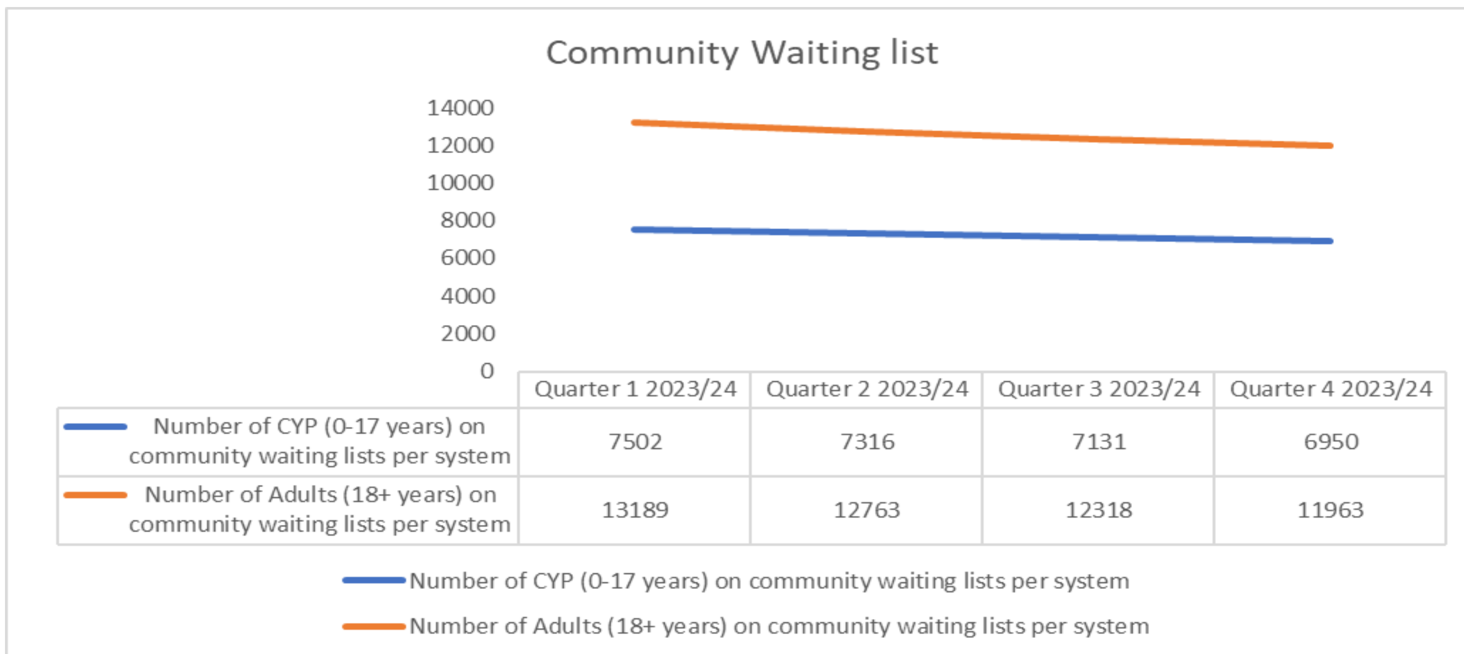
Across north east London, all places are working to improve discharge. The aim is to ensure faster discharges and that people are being moved into the correct place to support their needs. Although discharge is place based, the following are the common ambitions across the ICS:

- Encouraging a home first approach
- Continued improvement of the transfer of care hubs
- Promoting independence and reablement

**Some of the key work at Place in 23/24:**

- City and Hackney: An external evaluation of discharge is currently underway. The output from this 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 an integrated team.
- Waltham Forest: Implementing the Home First model including developing integrated rehab and reablement provision.
- In addition, across the Barts Health footprint: Delivery of the recommendations from a recent diagnostic undertaken by Newton Europe. Recommendations include ensuring we have Advance Care Planning, embedding Discharge to Assess, reduction in use of step down bed based provision, improved use of Intermediate Care and using digital tools to ease discharge process.
- Barking and Dagenham, Havering and Redbridge: The three Places that sit within the BHRUT footprint 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.
- Our key risks are: Financial – whilst we welcome the £600m investment in 23/24 it is a step down on current levels of funding and needs to be seen within the context of significant financial pressures in local authorities and Workforce – there are significant challenges in attracting and retaining people within the care sector.

# Community waiting list



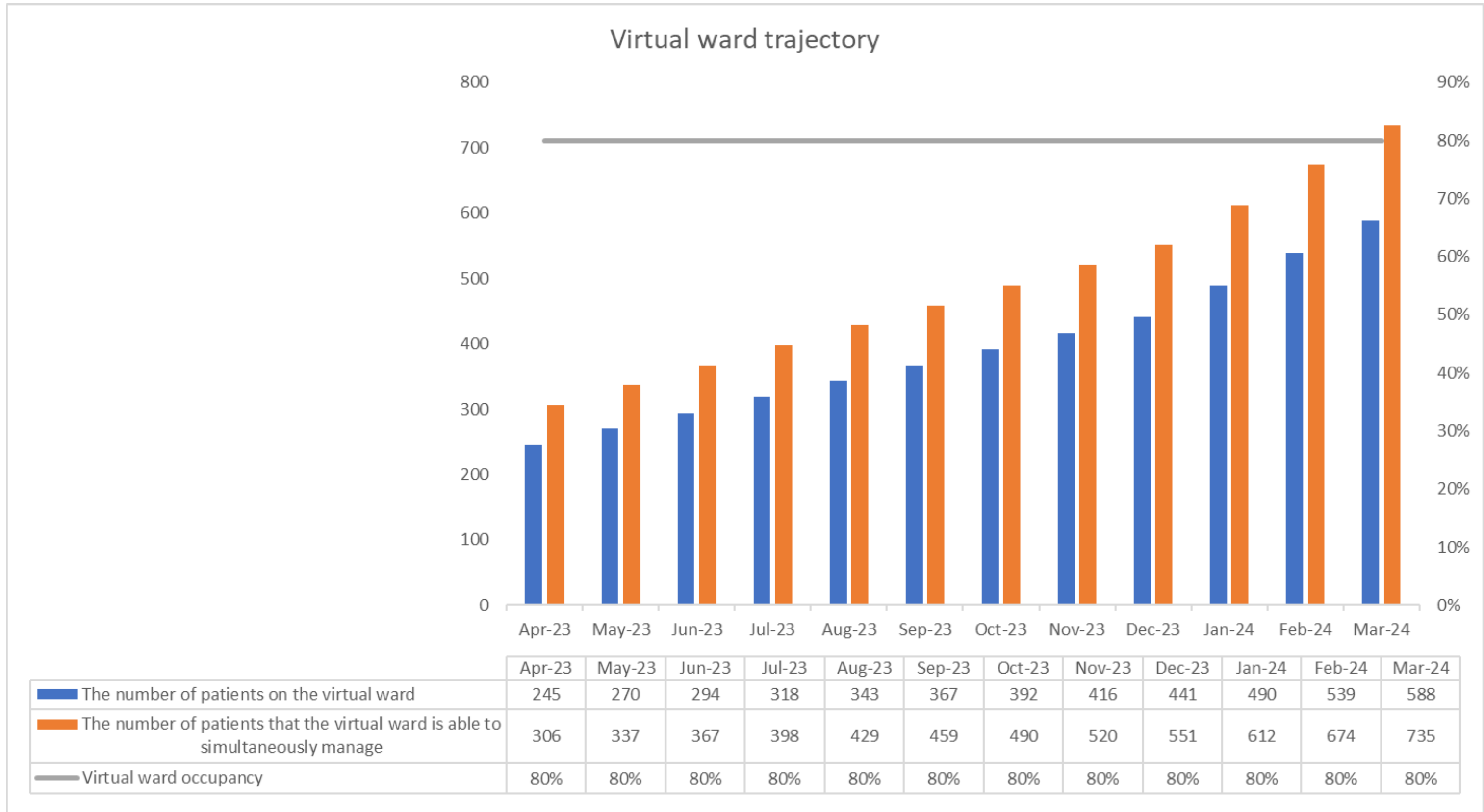

| | Quarter 1 2023/24 | Quarter 2 2023/24 | Quarter 3 2023/24 | Quarter 4 2023/24 |
|---|---|---|---|---|
| Number of CYP (0-17 years) on community waiting lists per system | 7502 | 7316 | 7131 | 6950 |
| Number of Adults (18+ years) on community waiting lists per system | 13189 | 12763 | 12318 | 11963 |

**Key risks to note:**

- Data quality issues in reporting.
- Particular challenges are around children's therapy services across NEL.
- Key issues impacting on waiting list are workforce, estate or demand.
- Data currently being reported by providers to NHSE is only at NEL or provider level, therefore difficult to enable place-based specific improvement discussions.

- In January 2023 for adults 88% were seen and treated within 18 weeks with 12% waiting over 18 weeks. For Children's 54% seen within 18 weeks with 46% seen over 18 weeks.
- The community waiting list is being reviewed and actioned through the community health collaborative and the place based partnerships.
- There are particular issues around data quality and consistency of reporting that is being actioned through the CHC.
- There are particular issues in children's therapy services which are being investigated and will be addressed through the CHC and place based partnerships.
- North-East London has identified that waiting times for Speech and Language Therapies for Children and Young People are significantly long in comparison to other ICB areas.
- The Community Health Collaborative is proposing an exercise be undertaken to identify the current provision delivered in each of the 7 Place-based Partnerships, to allow the sharing of best practice and the opportunity to identify where added value can be brought to these services to increase access.

# Virtual ward



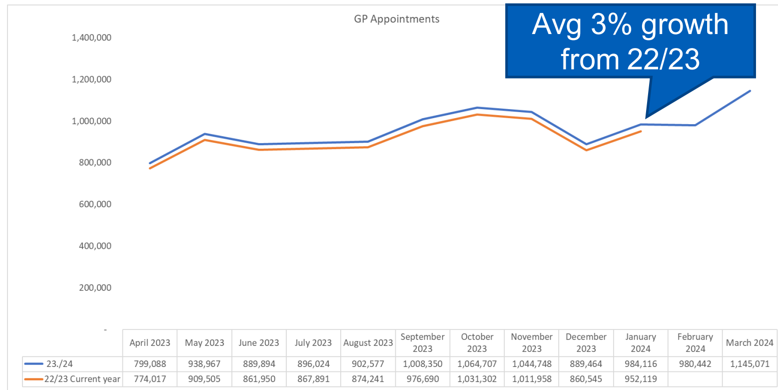

| | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| The number of patients on the virtual ward | 245 | 270 | 294 | 318 | 343 | 367 | 392 | 416 | 441 | 490 | 539 | 588 |
| The number of patients that the virtual ward is able to simultaneously manage | 306 | 337 | 367 | 398 | 429 | 459 | 490 | 520 | 551 | 612 | 674 | 735 |
| Virtual ward occupancy | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% |

- 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 Q1 to Q3 2023/24, with the aim of delivering 40 per 100,000 by Q4 March 2024.
- Current capacity stands at 174 beds throughout NEL.
- The control factors for the trajectory of patient numbers are the LOS (14 days) and occupancy levels (80%).
- We are not expecting substantive variances against previously submitted two-year trajectories for virtual ward capacity. However, we continue to have an ambition to grow bed provision in FY 23/24.
- We have taken a population health approach with data and delivery and prioritise our work and funding on areas where there is greatest population need. We will work with system leadership to drive growth of VW in 23/24 including improved links with our wider community services. The two national priority areas, Frailty and ARI are our focus however we are exploring a range of clinical pathways as VW matures including hospice at home, UCR and Care Home interfaces and more opportunities for growth to avoid admissions.
- £8m dedicated funding for virtual ward.

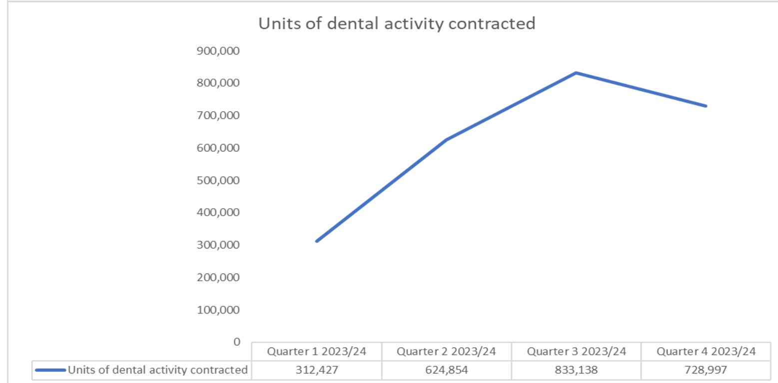
**Key risks to note:**

- Delivering 40-50 per 100’000 beds across NEL will be stretching.
- Current beds is at 23 per 100’000 and this is at maximum availability, while further work is happening to find additional capacity.

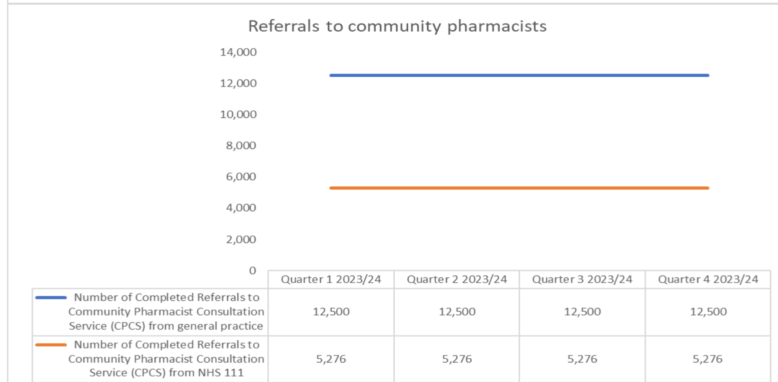
# Primary care




| | April 2023 | May 2023 | June 2023 | July 2023 | August 2023 | September 2023 | October 2023 | November 2023 | December 2023 | January 2024 | February 2024 | March 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 23./24 | 799,088 | 938,967 | 889,894 | 896,024 | 902,577 | 1,008,350 | 1,064,707 | 1,044,748 | 889,464 | 984,116 | 980,442 | 1,145,071 |
| 22/23 Current year | 774,017 | 909,505 | 861,950 | 867,891 | 874,241 | 976,690 | 1,031,302 | 1,011,958 | 860,545 | 952,119 | | |




| | Quarter 1 2023/24 | Quarter 2 2023/24 | Quarter 3 2023/24 | Quarter 4 2023/24 |
|---|---|---|---|---|
| Units of dental activity contracted | 312,427 | 624,854 | 833,138 | 728,997 |




| | Quarter 1 2023/24 | Quarter 2 2023/24 | Quarter 3 2023/24 | Quarter 4 2023/24 |
|---|---|---|---|---|
| Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from general practice | 12,500 | 12,500 | 12,500 | 12,500 |
| Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS 111 | 5,276 | 5,276 | 5,276 | 5,276 |

**Data Quality – Issues around data quality in relation to appointments in primary care.**

- Mitigations include work to improve data quality and data collection through the continued roll out of Edenbridge Apex in 2023/24. This currently covers 65% of practices. Edenbridge Apex is a tool that supports practices to evaluate changes in practice population trends, increases in healthcare demands and support quality improvement work focused around capacity, demand and unmet need.
- In addition, a clinical effectiveness scheme will be rolled out to support general practice to adopt standardised methods of clinical coding.

**The ability to manage increasing demand and expectation around access without unintended consequences impacting upon on quality**

- **Access and patient satisfaction:** despite appointment numbers increasing since 2019 patient demand continues to outstrip capacity, and patient satisfaction rates have reduced.
- A Quality Improvement programme is in place, focussing on practices across NEL with the greatest access challenges, providing diagnostic support and targeted interventions and coaching
- Using Clinical Effectiveness (CEG) data to monitor clinical outcomes and inform the type of appointments those with long term conditions are accessing to ensure this cohort are getting the right care at the right time by the most appropriate clinician. For some this may be that digital appointments are the best option, for others this will be face to face.
- Management of prevention activity, patient 'turnover' which is 30% which means prevention activity (such as calling patients for immunisation and screening) is harder to achieve.
- Through the fuller programme, focus upon new integrated pathways particularly around continuity of care for those patients in high prevalence groups with complex needs
- **Workforce capacity risk. PCNs are struggling to recruit and retain into ARRS roles (lack of suitably trained staff). There are also a number of GPs and nurses nearing the age of retirement.**
- Engagement and workforce planning with PCNs. Working with training hubs and academy regarding recruitment and retention initiatives and review supervision and education and training packages to make it an attractive place to work

**Risk that the Community Pharmacy Consultation Service (CPCS) is not fully utilised, freeing up capacity in general practice**

- The CPCS service is well established and embedded within NEL. 100% of practices are set up to refer and 93% are actively referring using Pharmacy Outcomes. The 7% that haven't been referring are being actively targeted to support them to engage with the service. There is also work being undertaken to expand the range of health conditions being treated by pharmacies, to help release further capacity in general practice.

**Dentistry – Increase in UDAs**

- Dental Funds/allocations
- Changes to contractual targets
- Increased need due to deterioration of oral health during pandemic
- Oral Health inequalities highlighted as a result of pandemic
- Commissioning Capacity following delegation

**Mitigations**

- Urgent Dental Care Hubs have been extended to March 2024 to ensure cover for patients in pain are seen asap.
- Procurement of new practices where loss of services have occurred and where highest needs have been identified.
- Stabilisation of patients that are unable to find a dentist and need treatment following urgent dental care.

# Mental Health and Learning Disability

| Metric | Compliance | 2023/24 Q4 Trajectory | Commentary |
| --- | --- | --- | --- |
| Inappropriate Out of Area Placement Bed Days | | 0 | • Compliant trajectory submitted<br>• Zero bed days in 2023/24 |
| Access to IAPT Services | | 14,244 (28.00%) | • Access rate growth but non-compliant trajectory submitted<br>• Unable at this point to commit sufficient financial resources to achieve full compliance given UEC pathway pressures.<br>• Speed of recruitment would make also full year compliance problematic. |
| Estimated Dementia Diagnosis rate | | 66.7% | • Compliant trajectory submitted<br>• 66.7% across 2023/24 |
| Women accessing Perinatal Mental Health services | | 2,803 (8.76%) | • Access rate growth but non-compliant trajectory submitted<br>• Unable at this point to commit sufficient financial resources to achieve full compliance given UEC pathway pressures.<br>• Speed of recruitment would make also full year compliance problematic. |
| Community access for adults with SMI | | 64,798 | • Compliant trajectory submitted<br>• 5% increase by the end of 2023/24 |
| Access to CYP services | | 24,322 (52.25%) | • Access rate growth but non-compliant trajectory submitted<br>• CYP Urgent Care expansion is not predicted to increase access<br>• Some places need to expand duration of treatment to meet rising acuity. This will not increase access. |
| Learning disability healthchecks | | 7000 | • Compliant trajectory achieving 75% of healthchecks in 23/25.<br>• There are some variation in performance at place and practice level. These variations are tracked and actioned through primary care and place quality reports. |
| Learning disability inpatients | | 23 (ICB commissioned)<br>20 (NHSE commissioned) | • Compliant trajectory with no more than 30 inpatients.<br>• A learning review is undertaken for all LD inpatients to understand how an admission could have been prevented. |

# Workforce position 2023-24 and governance

| NEL Summary Providers SIP | | SIP Growth | SIP Growth % | Baseline SIP | QT1 SIP | QT2 SIP | QT3 SIP | QT4 SIP | Current Vacancy | March '24 Vacancy |
|---|---|---|---|---|---|---|---|---|---|---|
| Workforce | Medical | 134 | 2.60% | 5185 | 4585 | 4610 | 4623 | 5319 | 5.90% | 3.80% |
| | Nursing | 1028 | 8.20% | 12468 | 12603 | 12782 | 13394 | 13496 | 17.50% | 10.60% |
| | Substantive Total | 2633 | 6.40% | 41080 | 40641 | 40945 | 42737 | 43714 | 11.70% | 6.00% |
| | Bank and Agency | -2447 | -33.30% | 7339 | 5782 | 5437 | 5132 | 4893 | N/A | N/A |
| | Total | 187 | 0.40% | 48420 | 46423 | 46382 | 47869 | 48606 | N/A | N/A |

| ICS Provider Summary | | 2022-23 | 2023-24 |
|---|---|---|---|
| Workforce | Permanent | 41,080 | 43,714 |
| | Bank | 5,014 | 3,697 |
| | Agency | 2,326 | 1,196 |
| | Total | 48,420 | 48,606 |

**Review of Planned Growth 2023-24 and intentions**

**Providers:** Significant planned growth of substantive staff across all main staff groups and significant reductions in bank and agency to meet operational plan requirements. Contingent on low sickness rates returning to pre pandemic %ages and reductions in turnover ranges from 3% to 4% on sickness absence and 11% to 13% on turnover.

**Key recruitment Plans:**

- Recruitment Nursing plans are a 50/50 split mix of domestic and international recruitment considerable numbers international recruitment utilising Capital Nurse. Plans developed in each provider but reviewed at regional level and monitored for specific roles and input through regional international recruitment, AHP council and Nursing through Chief Nurses Group.
- Local pipeline of Clinical support staff through well-developed local recruitment plans supported by mayoral academy work across the sector, linking into partnerships with Local colleges and local authorities building anchor networks to upskill and employ local people in our services.
- Key element of our medium to long term strategy is to develop this further with a focus on addressing inequality which a range of routes into jobs for our local population including increasing apprenticeships.

**Primary Care:**

- There is planned growth of 6.9% (22.7 FTE) for General Practice Nurses from March 2023 baseline to Q4.
- Expand the GP fellowship scheme with an aim to ensure that fellowships are offered in all PCNs.
- Recruit to MDT roles under the Additional roles reimbursement scheme.
- Key recruitment programmes through PCNs and NEL training hub to support workforce planning and interventions.

**Mental Health:**

- CYP Access – maintain levels of resourcing. Investment into perinatal services in order to ensure LTP access target is reflected with an accompanying workforce increase. Recruitment and plan development overseen by our Mental Health Transformation Board.

**Governance and Controls to manage growth and productivity**

**Working with providers to**

- Theatre utilisation programme to increase productivity from 65% to 85%
- Proactive sickness absence management and improved rostering practices to deliver efficiencies
- Recruitment plans that aims to achieve high level substantive fill rates and reduce reliance on temporary staff
- Controls to review of long-term agency and bank staff in positions that could be filled substantively
- Move to a bank first approach with appropriate controls i.e *NELFT Staff Bank Development -drawing on guidance in NHSEI Staff Bank Development toolkit and a variety of improvement activities*
- Develop consistent temporary staffing rates and governance ensuring alignment with rates across NEL and London
- To use collaboratives to drive specialised rates and agreements in Acute and Mental Health
- Reduction in premium rates for medical staff
- Increased temporary staffing recruitment events to recruit more staff to banks and reduce our reliance on agencies

**Primary Care:**

- During 2023/24 ,to achieve 90% conversion of trainees within the system footprint. Ensure that PCN and GP employers have access to workforce planning tools and information in 2022/23

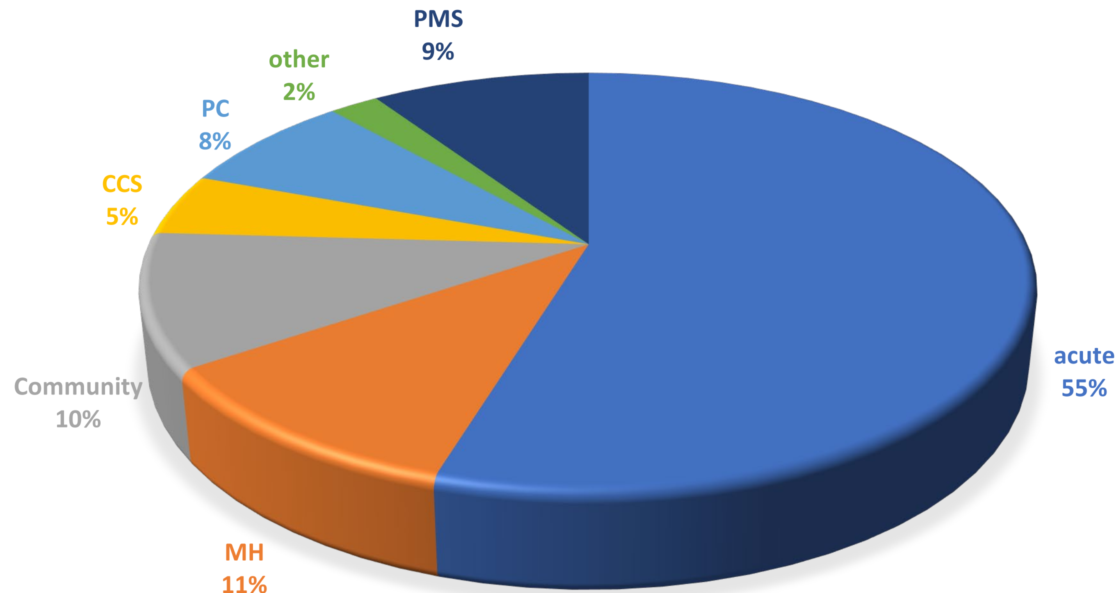
**ICS:**

- WF productivity Group to provide oversight of monitoring against the plan reviewing activity finance and workforce
- Strategic workforce developments through wider strategy development overseen by NEL People Board

# Workforce - Key lines of enquiry and actions

- Workforce and cost increases need to be aligned during triangulation.
- Focus on testing workforce costs against activity and delivery.
- Validating the pay costs in cost improvement programmes to ensure that they are robust.
- Any investment requirement for additional workforce is clearly understood and identified.
- Assurance on delivery on substantive recruitment plans, through monitoring of supply bridge plans with focus on:
    - Recruitment plans to reduce vacancies focusing on premium rate agency areas
    - Ensuring measures are taken to ensure sickness rates return to pre covid levels
    - Retention initiatives to reduce turnover to ensure vacancies are reduced.
- Productivity and bank and agency to be reviewed regularly through WF productivity group, comprising finance, medical, operations and people leaders.

# Finance: ICB 23/24 Plan Submission




- MH : mental health
- CCS: Continuing care services
- PC: primary care
- PMS: Primary medical services
- Other: program services
- Other : commissioned services

- NEL allocation for 23/24 of £4.18bn (excluding running costs)
- Acute services constitute by far the largest component of purchased care at 55% of all expenditure and the majority with the three acute providers Barts, BHRUT and HUH at c£1.8bn
- ICB plan submission will be break even
- Includes high degree of specific risk around inflationary pressures of c.£20m in prescribing and CHC to be managed through NR measures and /or benefits from inflation falling quicker than anticipated
- £88m of efficiencies assumed to be delivered with ongoing review opportunities to reduce expenditure

# Finance: ICS 23/24 Plan Submission

| | BHRUT | Barts | ELFT | HUH | NELFT | ICB | System Total |
|---|---|---|---|---|---|---|---|
| | £'m | £'m | £'m | £'m | £'m | £'m | £'m |
| 2022/23 FOT | -14.7 | -12.8 | 3 | 0 | 0 | 0 | -24.5 |
| 2023/24 Plan (30 March 2023) | | | | | | | |
| To submit | -19.8 | -50 | 0 | -3.6 | 0 | 0 | -73.4 |
| Risk | -20 | -19 | -8 | -8 | -3.5 | -22 | -80.5 |
| Total | -39.8 | -69 | -8 | -11.6 | -3.5 | -22 | -153.9 |

- System deficit at £73.4m. This falls within the range agreed with regional colleagues
- Indicates a worsening financial position form 22/23 of £45m and an additional risk which is currently unmitigated at £80m.
- 22/23 required system significant NR measures (c.£145m) to cover inflation and other cost pressures. Covid income changes in 23/24 contributes directly to £30m cost pressure in 23/24.
- Providers not in balance will be entered into SoF4 intervention, the impact on ICS may be continuation of recently introduced financial arrangements requiring NHSE oversight of expenditure over certain value.
- All system funding, except c£21m growth funding, allocated to providers in plan
- The deficit and risk is after 23/24 system efficiency assumption of c.£225m which is a £75m increase on the 22/23 requirement.
- As a percentage of turnover the total efficiency equates to 3.9% in 23/24

- Risks in plan include:
- 22/23 energy costs at Barts were competitive, so while starting from a lower base and at a lower level than many , the rate of increase was in excess of the funding
- RPI contracts including NHS properties and other commercial arrangements include RPI and will bake in increases above funded inflation irrespective of the headline inflation trajectories
- Non funded CNST increases from 22/23 are a not insignificant part of the current plan deficit
- Delivery of efficiencies - £225m currently delivers a £150m deficit if risks cannot be contined. Continue working in identifying new opportunities to de risk the current £225m and scope for increasing.
- Ongoing strike action
- Winter pressures and other respiratory illnesses reflect funding and expose us to financial and delivery risk under certain scenarios
- Above target expectation of agency use continue to exert a cost pressure
- Delivery of ERF in plan at marginal costs, however, to deliver ERF in full may require additional costs

# Finance: Capital

- Capital funding for NEL is insufficient for the upkeep and development clinical assets necessary to deliver healthcare to NEL patients.
- By a number of measures it can be demonstrated that NEL is underfunded in capital, due in part to the nature of the national allocation formula, having two large PFI builds and historic under investments (perpetuated by a formula that is based on existing asset valuations (not land) and depreciation).
- London are supportive of NEL with regards seeking additional support from national
- 2022/23 plan will be balanced only delaying costs into 23/24, to the value of c.£11m, adding further pressure onto already overcommitted available
- The NEL allocation for 23/24 is £91m. The draft submission was for £174m and submissions to the clinical prioritisation process currently underway totalled in excess of £380m.
- Illustrating the pent up demand for investment in both physical estate, medical equipment and digital

- We will submit a 23/24 plan that is financially compliant
- If investments in 23/24 are limited to just work in progress, deferred costs , legal obligations and match funding :
  - Year end 22/23 costs deferred into 23/24 £11m
  - match fund essential EPR work at BHRUT £11m,
  - remedial fire works at Barts £17m,
  - completion of HUH ITU build £8m,
  - St Georges £7m
  - costs over TIF funds for Newham Modular build £6m.
  - National program slippage £10m
  - Projects already under construction £10m from 22/23
  - Contractual commitments £12m
  - Those items total £92m
- This does not address any routine essential repairs or replacement programs and certainly no funds for emergency replacements.
- Our next step is a detailed 3 year evidenced, risk assessed and costed plan to understand the full nature of the shortfall and the impact potentially on our ability to deliver patient care.
- London will work with and support us in seeking additional funds to enable a safe capital program to be funded in 23/24