City & Hackney Health and Care Board Sub Committee

Wednesday 13 November 2024, 1400-1600

Chair: Helen Fentimen

AGENDA

	Item	Time	Lead	Attached / verbal	Action required
1.0	**Welcome, introductions and apologies:** • Declaration of conflicts of interest • Minutes of the Development Session held on 11 September 2024 • Action Log • Matters Arising	1400 (5 mins)	Chair	*Papers 1a,1b & 1c* Pages 3-12	Note Note Approve Note
2.0	**Questions from the Public**	1405 (5 mins)	Chair	Verbal	Discuss
3.0	**Place Lead update**	1410 (5 mins)	Bas Sadiq	Verbal	Discuss
4.0	**Progress on the Place Development Work** • **City and Hackney Executive Partnership Terms of Reference**	14:15 (15 mins)	Bas Sadiq / Amy Wilkinson Jonathan McShane	Verbal *Paper 4* Pages 13-17	Discuss Approve
5.0	**Primary Care Enhanced Contract**	14:30 (20 mins)	Stephanie Coughlin	*Paper 5* Pages 18-35	Discuss
6.0	**Winter Planning**	14:50 (15 mins)	Anna Hanbury	*Paper 6* Pages 36-55	Approve

7.0	**City and Hackney Immunisations Strategic Action Plan**	1505 (20 mins)	Sarah Darcy / Bryn White	*Paper 7* Pages 56-92	Approve
8.0	**Anti Racism Work** • **NEL Anti Racism Strategy** • **January follow-up session on Anti-Racism**	1525 (30 mins)	 Lee Walker Dee Brecker	*Paper 8* Pages 93-135	Discuss Note
9.0	**Any Other Business**	1555 (5 mins)	Chair	Verbal	Discuss
Development session to be held on: Wednesday 08 January 2025					

- Declared Interests as at 28/10/2024

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
Chetan Vyas	Director of Quality	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Clinical Advisory Group Havering ICB Sub-committee Havering Partnership Board ICB Quality, Safety & Improvement Committee Newham Health and Care Partnership Newham ICB Sub-committee Patient Choice Panel Procurement Group Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	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
			Indirect Interest	Some GP practices across NEL	Family members are registered patients - all practices not known nor are their registration dates	2014-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Borough of Hackney	Cabinet Member for Health, Adult Social Care, Voluntary Sector and Leisure in London Borough of Hackney	2020-07-09		
			Non-Financial Personal Interest	Lee Valley Regional Park Authority	Member of Lee Valley Regional Park Authority	2020-07-09		
			Non-Financial Personal Interest	Hackney Empire	Member of Hackney Empire	2020-07-09		
Christopher Kennedy	Councillor	City & Hackney ICB Sub-committee City & Hackney Partnership	Non-Financial Personal Interest	Hackney Parochial Charity	Member of Hackney Parochial Charity	2020-07-09		

		Board ICB Board ICB Finance, Performance & Investment Committee ICP Committee						
			Non-Financial Personal Interest	Labour Party	Member of the Labour Party	2020-07-09		
			Non-Financial Personal Interest	Local GP practice	Registered patient with a local GP practice	2020-07-09		
			Non-Financial Personal Interest	Hackney Joint Estate Charities	sit in the borad as trustee	2014-04-07		
			Non-Financial Personal Interest	CREATE London	LBH appointed rep	2023-04-05		
Dr Stephanie Coughlin	ICP Clinical Lead City & Hackney	City & Hackney ICB Sub-committee City & Hackney Partnership Board Clinical Advisory Group	Non-Financial Professional Interest	Lower Clapton Group Practice	GP Principal at Lower Clapton Group Practice	2020-10-09		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	British Medical Association	Member of the British Medical Association	2020-10-09		
			Non-Financial Professional Interest	Royal College of General Practitioners	Member of the Royal College of General Practitioners	2020-10-09		
Helen Fentimen	Common Council Member	City & Hackney ICB Sub-committee City & Hackney Partnership Board	Non-Financial Professional Interest	City of London Corporation	Common Council Member of the City of London Corporation	2020-02-14		
			Non-Financial Personal Interest	Labour Party	Member of the Labour Party	2020-02-14		
			Non-Financial Personal Interest	Unite Trade Union	Member of Unite Trade Union	2020-02-14		
			Non-Financial Personal Interest	Prior Weston Primary School and Children's Centre	Chair of the Governors, Prior Weston Primary School and Children's Centre	2020-02-14		
John Gieve	Chair of Homerton Healthcare	Acute Provider Collaborative Joint Committee City & Hackney ICB Sub-committee City & Hackney Partnership Board ICP Committee	Non-Financial Professional Interest	Homerton Healthcare NHS Foundation Trust	I am Chair of Homerton Healthcare whose interests are affected by ICP and City and Hackney Parnership decisions	2019-03-01		

Kirsten Brown	Primary Care Clinical Lead for City and Hackney	City & Hackney ICB Sub-committee City & Hackney Partnership Board Primary Care Collaborative sub-committee	Financial Interest	Lawson Practice Partnership	I am a GP partner at Lawson Practice and Spring Hill Practice	2013-02-01		Declarations to be made at the beginning of meetings
			Financial Interest	City and Hackney GP Confederation	I am a partner at the Lawson Practice and Spring Hill Practice both of which are member practices of City and Hackney GP confederation	2013-02-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	UCLH	I am a patient at UCLH	2017-06-01		
Sandra Husbands	Member of a committee	City & Hackney ICB Sub-committee City & Hackney Partnership Board Clinical Advisory Group	Non-Financial Professional Interest	Association of Directors of Public Health	Board member and trustee	2023-02-28		
			Non-Financial Professional Interest	Imperial Health Charity	Trustee	2022-08-22		

- Nil Interests Declared as of 28/10/2024

Name	Position/Relationship with ICB	Committees	Declared Interest
Stella Okonkwo	Head of Strategic Planning and PMO	City & Hackney ICB Sub-committee City & Hackney Partnership Board	Indicated No Conflicts To Declare.
Sunil Thakker	Director of Finance and Partnership Services	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 Audit and Risk Committee ICB Finance, Performance & Investment Committee Newham Health and Care Partnership Newham ICB Sub-committee Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Jenny Darkwah	Clinical Director, Shoreditch Park and City Primary Care Network	City & Hackney ICB Sub-committee City & Hackney Partnership Board	Indicated No Conflicts To Declare.
Jacquie Burke	Group Director, Children and Education	City & Hackney ICB Sub-committee	Indicated No Conflicts To Declare.

		City & Hackney Partnership Board	
Helen Woodland	Group Director, Adults, Health and Integration	City & Hackney ICB Sub-committee City & Hackney Partnership Board Community Health Collaborative sub-committee	Indicated No Conflicts To Declare.
Simon Cribbens	Assistant Director - Commissioning and Partnerships	City & Hackney ICB Sub-committee City & Hackney Partnership Board	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 Community Health Collaborative sub-committee Havering ICB Sub-committee Havering Partnership Board ICB Audit and Risk Committee 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 Patient Choice Panel Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Alison Glynn	Deputy Director Operations, Finance and Contracting	City & Hackney ICB Sub-committee City & Hackney Partnership Board Patient Choice Panel	Indicated No Conflicts To Declare.
Basirat Sadiq	Deputy Chief Executive Homerton Healthcare	City & Hackney ICB Sub-committee City & Hackney Partnership Board Community Health Collaborative sub-committee ICB Population, Health & Integration Committee	Indicated No Conflicts To Declare.
Rachel Cleave	Member of NEL ICB and ICP	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICB Population, Health & Integration Committee ICP Committee	Indicated No Conflicts To Declare.
Lorraine Sunduza	Interim Chief Executive	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee	Indicated No Conflicts To Declare.
Judith Finlay	Executive Director of Community and Childrens services	City & Hackney ICB Sub-committee City & Hackney Partnership Board	Indicated No Conflicts To Declare.
Amy Wilkinson	Director of Partnerships, Impact and Delivery	City & Hackney ICB Sub-committee City & Hackney Partnership Board Primary care contracts sub-committee	Indicated No Conflicts To Declare.
Dawn Carter-McDonald	Member of a committee	City & Hackney ICB Sub-committee City & Hackney Partnership Board	Indicated No Conflicts To Declare.

Jackie Moylan	Member of a committee - Group Director, Finance	City & Hackney ICB Sub-committee City & Hackney Partnership Board	Indicated No Conflicts To Declare.
Mary Durcan	member of a committee	City & Hackney ICB Sub-committee ICP Committee	Indicated No Conflicts To Declare.
Matt Bray	Interim Co-CEO & Director of Comms & VCS Support	City & Hackney ICB Sub-committee City & Hackney Partnership Board	Indicated No Conflicts To Declare.

Notes of the City & Hackney Health and Care Board Development Session
Wednesday 11 September 2024, 14:00-1600
Committee Room, Hackney Town Hall, Mare Street E8 1EA

Members:	
Helen Fentimen (HF) - Chair	Chairman, Community and Children's Services Committee, City of London Corporation
Cllr Chris Kennedy (CK)	Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture, London Borough of Hackney
Helen Fentimen (HF)	Chairman, Community and Children's Services Committee, City of London Corporation
Sunil Thakker (ST)	Director of Finance, NHS North East London
Robert Chapman (RC)	Cabinet Member for Finance, Insourcing and Customer Service, London Borough of Hackney
Dr Stephanie Coughlin (SC)	Clinical Care Director, NHS North East London
Basirat Sadiq (BS)	Chief Executive Officer, Homerton Healthcare NHS Foundation Trust
Amy Wilkinson (AW)	Director of Partnerships, Impact and Delivery, NHS North East London
Matt Bray (MB)	Interim Co Chief Executive Officer, Hackney Council for Voluntary Services
Alison Glynn (AG)	Deputy Director Operations, Finance and Contracting, City and Hackney Place, NHS North East London
Helen Woodland (HW)	Group Director, Adults, Health and Integration, London Borough of Hackney
Judith Finlay (JF)	Director of Community and Children's Services, City of London Corporation
Haren Patel (HP)	PCN representative, Primary Care Networks
Simon Cribbens (SC)	Director, Community & Children's' Services, City of London Corporation
Andreas Lambrianou (AL)	Chief Executive Officer, City & Hackney GP Confederation
Sally Beaven (SB)	Executive Director, Healthwatch Hackney
Rachel Cleave (RC)	General Manager, Healthwatch City of London
Dawn Carter McDonald (DCM)	Interim Chief Executive, London Borough of Hackney
Caroline Millar (CM)	Chair, City & Hackney GP Confederation
Dr Anu Kumar (AK)	Chair of the People and Place Group, City and Hackney
Sir John Gieve (JG)	Chair, Homerton Healthcare NHS Foundation Trust
Richard Fradgley (RF) (Deputised for Lorraine Sunduza)	Director of Integrated Care & Deputy Chief Executive Officer, East London NHS Foundation Trust
Attendees:	
Shakila Talukdar (ST)	Governance Officer, NHS North East London (minutes)
Jonathan McShane (JMS)	Integrated Care Convener, NHS North East London
Stella Okonkwo (SO)	Head of Strategic Planning and PMO, NHS North East London
Deirdre Worrell (DW)	Interim Director of Financial Management, Hackney Council
Dee Brecker (DB)	Ginkgo Coaching & Consulting - Facilitator
Rowena Estwick (RE)	Ginkgo Coaching & Consulting - Facilitator
Carole Williams (CW)	Cabinet Lead for Equalities, London Borough of Hackney
Debra Robinson (DR)	Hackney Children and Education Directorate, London Borough of Hackney
Victoria Beckwith (VB)	Equality Diversity and Inclusion Lead, Homerton Healthcare NHS Foundation Trust
Apologies:	

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Lorraine Sunduza (LS)	Chief Executive, East London NHS Foundation Trust
Dr Kirsten Brown (KB)	Primary Care Development Clinical Lead
Dr Sandra Husbands (SH)	Director of Public Health, London Borough of Hackney / City of London Corporation
Mary Durcan (MD)	Chairman, Health and Wellbeing Board, City of London Corporation
Agnes Kasprowicz (AK)	PCN representative, Primary Care Networks
Jacquie Burke (JB)	Group Director, Children and Education, London Borough of Hackney
Caroline Woodley (CW)	Elected Mayor, London Borough of Hackney
Jackie Moylan (JM)	Group Director, Finance, London Borough of Hackney
Charlotte Pomery (CP)	Chief Participation and Place Officer, NHS North East London
Tehseen Khan (TK)	PCN representative, Primary Care Networks
Mark Jarvis (MJ)	Head Of Finance, City of London Corporation
Anntoinette Bramble (AB)	Deputy Mayor and Cabinet Member for Education, Young People and Children's Social Care, London Borough of Hackney
Ceri Wilkins (CW)	Elected Member, City of London Corporation
Ruby Sayed (RS)	Deputy Chairman, Community & Children's' Services Sub-Committee, City of London Corporation
Reza Paruk (RP)	Assistant Director of Finance (Adults Health and Integration), London Borough of Hackney
Chetan Vyas (CV)	Director of Quality and Safety, NHS North East London

Item No.	Item title
1.	**Welcome, Introductions and apologies** The chair welcomed members and attendees to the meeting and highlighted the apologies as listed above. **1.1 Declarations 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 City and Hackney Health and Care Board. No additional conflicts were declared. **1.2 Minutes of the City & Hackney Health and Care Sub Committee and Integrated Care Board Development Session held on 10 July 2024** The board approved and agreed the minutes as an accurate reflection of the meeting. **1.3 Action Log** There were no open actions discussed. **Matters Arising** There were no matters arising discussed.
2.	**Place Lead update**
	Bas Sadiq (BS) provided the Board a verbal update and highlighted the following: • New health Secretary Wes Streeting has highlighted 3 priorities for health: 1.Shift from hospital to community 2. Shift from analogue to digital 3. Shift from treatment to prevention.

	• Winter planning has started, the ageing well team are supporting partners at the Homerton. • Welcomed Matt Bray who is the Interim Co Chief Executive Officer for Hackney Council for Voluntary Services (HCVS). • Amanda Pritchard CEO of NHSE and Caroline Clarke, London Regional Director will be visiting City and Hackney to look at what leadership and pathways look like and see partnership in action in one of the GP practices. • Homerton fertility clinic suspension was lifted at the end of August, working with stakeholders to resume service.
3.	**Finance Update**
	Sunil Thakker (ST) presented the circulated paper to the Board for information and highlighted: This is the new finance report showing Place level information. • The purpose of this report is to provide an overview of the financial position for the ICB and ICS and City & Hackney Place. • The paper outlines the financial performance for the ICB and ICS, showing a year-to-date £43.5m deficit. This is made up of a provider deficit to plan of £37.8m and ICB deficit to plan of £5.7m. • The ICS submitted an operating plan forecast deficit of £35m (provider deficit of £35.6m and ICB surplus of £0.6m). • Delivery of the ICB's year-end position is dependent on the delivery of the cost improvement programme (CIP). Slides 22-24 set out progress against delivery plans. • The paper also sets out activity and budgets at Place where these are available. This includes information on acute, community, prescribing and primary care services. Comments and questions from the board included: • Board noted the finance updates for month four and noted that placed based summary remains a work in progress. • Asked to see place based figures looking at more detail on prescribing locally and to look at figures in other areas in more depth at the future Board meetings. • Flagged impact of mitigation on place and some of the activities, suggested to have discussion at a future Board on what to do from a local perspective to help impact on the flow into acute as well as flow out of acute and through A&E / ward-based activities. • Suggested to be clear on three headings, community, digitalisation, and prevention. Will be brought back to the next business focused Board meeting in November 2024. **London Borough of Hackney Finance Update** The chair asked the board to note the papers. A more detailed update will come back to the next Board meeting.
Development Session	
4.	**Anti-racism Workshop**
	Dee Brecker (DB) and Rowena Estwick (RE) facilitated the Anti-Racism workshop with the Board. A summary of the materials used, and the discussion prepared by the facilitators is attached as an appendix. SHARED_CityHackney HeathCareBoard Development Session.pdf

5.	**Any Other Business:** There was no other business discussed.
	Date of next meeting: Wednesday 13 November 2024, 1400-1600 online by Teams

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City & Hackney Health and Care Partnership Action Log

Action Ref	Action Raised Date	Action Description	Action Lead(s)	Action Due Date	Action Status	Action Update
1303-03	13-Mar-24	We need to be more specific around BAME data and include drilled down data regarding City and Hackney particularly in areas such as women in prenatal care, mental health (Black people). To also report if there is a theme that needs to be picked up. Anna Garner (AG) to include this level of data in the report.	Anna Garner	08-Jan-25	In progress	This will be included in the more detailed outcomes updates. The Inequalities will be reflected in the outcomes work for every area and is on the forward planner for January 2025.

City and Hackney Health and Care Board

13 November 2024

Title of report	Place governance changes – establishment of City and Hackney Executive Partnership
Author	Jonathan McShane, Integrated Care Convenor
Presented by	Jonathan McShane, Integrated Care Convenor
Contact for further information	Jonathan McShane
Executive summary	At the Health and Care Board in July, members approved the direction of travel set out to make changes to place based governance. This included changes to the focus of the Health and Care Board and the Neighbourhoods Health and Care Board. It also included changing the name of the NHCB to the City and Hackney Executive Partnership.
Action / recommendation	The Board/Committee is asked to approve the establishment of the partnership.
Previous reporting	Neighbourhoods Health and Care Board, September.
Next steps/ onward reporting	None
Conflicts of interest	None
Strategic fit	Which of the ICS aims does this report align with? • 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 proposed changes to governance aim to provide better focus on key priorities
Has an Equalities Impact Assessment been carried out?	None
Impact on finance, performance and quality	The proposed changes to governance aim to provide better focus on key priorities
Risks	None

City and Hackney Executive Partnership

Terms of Reference

1. Context

There is a need for clear and robust governance for health and care at place. The governance structure should enable a sharp focus on key issues, and a better cadence of flow of business through the local system.

A key part of achieving this is the establishment of the **City and Hackney Partnership**, building on the work of the Neighbourhood Health and Care Board

The City and Hackney Place based governance includes two other main bodies:

- **City and Hackney Health and Care Board** – includes the place committee of the North- East London ICB and sets the strategic direction for place. This body agrees all decisions relating to s75 agreements between the local authorities and the NHS.
- **Delivery Group** – focused on operational delivery of services and programmes

The City and Hackney Partnership, as part of local governance arrangements, has been tasked with the delivery of the vision and strategy for the partnership set by the City and Hackney Health and Care Board (CHHCB) and will receive assurance on the development and delivery of service proposals and the integrated delivery plan from the Delivery Group.

2. Purpose

2.1 The partnership's role is to bring together senior managers from across the system to support delivery of the place strategy by overseeing the following:

- How the system is working together
- Progress on key priorities
- Finance and performance

2.2 The partnership will act within its role (as an executive partnership group) as a governance route for joint decision making by partners in relation to operational delivery, use and prioritisation of local system resources, and management of local system performance in relation to the strategies agreed by the City and Hackney Health and Care Board.

2.3 The partnership will be the place where the detail of any s.75 or s.256 agreements is discussed, and proposals developed to be approved formally by the City and Hackney Health and Care board.

2.4 As part of its oversight of finance at place, the partnership will oversee the delivery of initiatives that support efficiency programmes at place and ICB level.

2.5 The partnership will provide oversight of the Integrated Delivery Plan and oversee the development of any joint proposals in relation to local services or transformation in City and Hackney ensuring they are ready for strategic discussion and formal approval at future meetings of the City and Hackney Health and Care Board.

2.6 The partnership will oversee delivery of the place strategy

2.6.1 In relation to the three major programme areas:

- Age and live well
- Start well
- Mental health

2.6.2 And in relation to the five strategic enabler areas:

- Workforce
- Voluntary, Community & Social Enterprise Sector (VCSE)
- Communication & Engagement
- Data & Digital
- Estates & Assets
- Finance & Contracting

2.7 The partnership will also oversee delivery of three cross cutting priorities:

- Strategic integrated commissioning
- Neighbourhoods
- Prevention and population health management

3. Membership and attendance

3.1. The partnership will be chaired by the Place Based Leader and the Place Clinical Director will be the Vice Chair.

3.2. The core membership will be:

- Accountable Officer, East London NHS Foundation Trust (ELFT)
- Accountable Officer, City and Hackney Integrated Primary Care
- Accountable Officer, Homerton Healthcare NHS Foundation Trust (HUH)
- Group Director, responsible for adult services, London Borough Hackney (LBH)
- Group Director, responsible for children's services, London Borough Hackney (LBH)
- Director, responsible for health and social care, City of London Corporation (CLC)
- Director of Public Health, City of London & London Borough of Hackney

- PbP Finance Director
- PbP Director of Partnerships, Impact and Delivery
- Two Primary Care Network Clinical Directors
- Senior representative, HCVS

In addition, SROs for the three major programme areas will attend if they are not included above.

3.3. Others may be asked to attend for specific agenda items including representatives of VCS organisations relevant to the items being discussed.

3.4. The meeting will be quorate when over 50% of the total membership is present, with a requirement that at least one practitioner is present within that 50%. Named representatives from core member organisations can nominate appropriately senior individuals as standing deputies if they are unable to attend.

4. Accountability and reporting

4.1. The City and Hackney Executive Partnership will report to the City and Hackney Health and Care Board.

5. Meetings and administration

5.1. The City and Hackney Executive Partnership will meet Bi-monthly. Additional meetings may be convened when the Chair deems it necessary.

5.2. The partnership will not meet in public but will operate under the principles of transparency and openness expected of statutory public bodies.

5.3. The aim will be for decisions of the partnership to be achieved by consensus decision making. Voting will not be used, except as a tool to measure support or otherwise for a proposal. In such a case, a vote in favour would be non-binding. The Chair will work to establish unanimity as the basis for all decisions.

5.4. Meetings will be minuted, and copies of minutes and action logs will be circulated to members for accuracy alongside other relevant papers for the meeting.

5.5. The partnership will be supported by the local PMO team.

6. Programme Boards

6.1. In order to assist it with performing its role and responsibilities, the partnership is authorised to establish Programme Boards and to determine the membership, role and remit for each Programme Board. Any Programme Boards established by the partnership will report directly to it.

6.2. Initial Programme Boards will be:

- Age and live well

- Start well
- Mental health

6.3. Each Programme Board will have 2 Senior Responsible Officers, one from a local authority and one from a provider organisation.

6.4. The strategic enabler groups will support delivery of the place strategy.

7**. Review of these Terms of Reference**

7.1. The partnership will review these terms of reference every year.

8. Conflicts of Interests

8.1. A declaration of interests register will be completed by all members and attendees of this meeting and will be kept up to date in line with the policies on managing conflicts of interest of each partner organisation. A register of interests will be brought to every meeting and included on the agenda as a standing item.

8.2. Additionally, all attendees should be reminded to review the agenda and consider whether any topics being discussed might present an area of interest. This means an item where a decision or recommendation made may advantage that person, their family, and/or their workplace. These advantages might be financial or in another form, perhaps the ability to exert unseen influence.

8.3. Where anything on the agenda or raised in the meeting has the potential to create such a conflict, it should be raised with the Chair. This means we can ensure that our decisions, recommendations, or actions can be guarded from the impact of any possible conflict attendees could have and be seen to be so. Attendees should, where possible, raise such issues before the meeting, or as soon as a potential conflict becomes apparent. This openness is important so that all can discuss how to manage decision making in a complex environment and learn together how to manage these issues well.

City & Hackney Health & Care Board

13th of November 2024

Title of report	**Recommissioning Primary Care Enhanced Services**
Author	Matt Hopkinson - Programme Delivery Manager, Start Well / Age Well, City & Hackney Place-Based Partnership, NHS North East London ICB
Presented by	Dr Stephanie Coughlin – Clinical Director, City & Hackney Place Based Partnership
Contact for further information	Stephanie Coughlin / Matt Hopkinson
Executive summary	This paper sets out a case in support of commissioning Primary Care Enhanced Services (PCES) to improve health outcomes, reduce inequalities, and ensure sustainable delivery of high-quality care for the residents and patients in City & Hackney. 13 Enhanced Services in City & Hackney are currently commissioned from primary care with the aim of improving health outcomes, reducing inequalities, and ensuring sustainable delivery of high-quality care for the residents and patients in City & Hackney. This paper sets out, at a high level, the key outcomes and the additional value that each of these services provides to City & Hackney; and makes a case for their recommissioning once the current contract expires on 31 March 2025. The paper provides an overarching view, based on a foundation of service reviews and business case development carried out by the Enhanced Services Working Group between November 2023 and June 2024. **Current Position** The current PCES contract expires on 31 March 2025. Recurrent funding is in place within current budgets and there is a general commitment within NEL to work towards levelling up across places, but we acknowledge the wider context of financial pressure and deficit within NHS NEL ICB. The impacts would be severe if services were not extended (*see Risk section, below*) and it is essential that a strong case is made in support of the services. Given the ongoing review of enhanced services across North East London by the NHS NEL Primary Care team and the timescales involved in re-commissioning, it is possible that NHS NEL ICB will need to roll-over existing contracts for a

	further year to allow time for a more detailed review of primary care locally enhanced services across NEL. This paper sets out an outline case to support awarding a contract for a further 5-7 year period, with a flexible framework that would enable us to add or vary specific services in accordance with changing context over the lifetime of the contract. **Work in Progress** The case presented below is a work in progress. Further content will be added to support the case around affordability and value for money, based on analysis which is being carried out at North-East London level by the NEL Primary Care Team, allowing more detailed consideration of quantitative data from Secondary Care and comparisons with other boroughs and trusts within North East London.
Action / recommendation	The Board/Committee is asked to: • **NOTE** the enhanced primary care services currently provided within City & Hackney; their contribution to improving health outcomes, reducing inequalities and ensuring sustainable delivery of high-quality care for residents and patients. • **NOTE** the risks to health and wellbeing and to the sustainability of primary and secondary care if these services were not recommissioned going forward. • **ENDORSE** the case set out in the detail of the paper to support recommissioning of Primary Care Enhanced Services in City & Hackney by NHS North East London ICB.
Previous reporting	City & Hackney General Practice Strategy Board – 17 July 2024 GP Enhanced Services Working Group – June 2024
Next steps/ onward reporting	The business case will be presented to NHS North East London ICB Investment Review Group and Procurement Group (as well as other groups as appropriate) – timescale to be determined.
Conflicts of interest	N/A
Strategic fit	This report aligns with the following 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 Further detail on alignment with strategic priorities is set out below.

Impact on local people, health inequalities and sustainability	Enhanced Primary Care Services in City & Hackney have a proven track record of delivering high-quality care that measurably improved patient outcomes, with a particular focus on reducing health inequalities affecting disadvantaged groups in the community (*see page 7-9 of main report, below*). Investment in these services strengthens the foundation for sustainable primary care services in general and builds resilience to meet the community's evolving needs (*see page 11-12 of main report, below).*
Has an Equalities Impact Assessment been carried out?	Equalities Impact Assessments were undertaken in the development of each of the services covered within this business case. Addressing health and wellbeing inequalities is a core element of service design and outcomes.
Impact on finance, performance and quality	The Primary Care Enhanced Services discussed in the report have been in operation for a number of years. All services have recurrent funding currently in place. Total annual costs of all 13 services amounts to £11,275,369 (based on figures for 2023/24). There are no additional resource implications anticipated beyond existing service costs (and any inflationary uplifts to be applied during the lifetime of the contract). A number of the services provide significant cost-savings through optimising utilisation of health-system resources (*see p.11-12 of main report, below)*)
Risks	A decision to not continue commissioning of Primary Care Enhanced Services would pose significant risks to the health and wellbeing of patients and to the sustainability of the local system and other key health and care providers across City & Hackney: • If we fail to commission proactive provision for patients with Long Term Conditions, Serious Mental Illness, at End of Life or at risk of deterioration and unwarranted health outcomes, patients' health, happiness and independence will suffer and they will deteriorate at a greater rate than if they had received appropriate levels of support. • The long-term investment in primary care provided by this contract is essential to the financial stability and viability of practices in City & Hackney. The additional resources provided by the primary care enhanced service contracts funds permanent GP practice staff that are responsible for delivering on the contract KPIs. Withdrawal of this funding would create a crisis

	in primary care and undermine its delivery of quality care for residents. • We would see major increase in avoidable admissions and A&E attendances as poorly managed LTCs result in more disease complications at an earlier age and an increase in avoidable serious medical conditions. We would expect there to be significant additional pressures for Homerton Healthcare, East London Foundation Trust as well as care services provided by the local authority. • Similarly, if Duty Doctor was not continued, we would see an immediate very large increase in A&E attendances from people needing same-day access to urgent primary care. This would be likely to lead to poor experiences for the patient and worse outcomes than if they had been supported out of hospital, as well as unsustainable levels of demand and costs in secondary care.

SECTION 1 - EXECUTIVE SUMMARY

Background

Primary Care Enhanced Services (PCES) provide additional, specialised services outside of national GP contracts, addressing specific health needs within the community. These services are designed to enhance the quality of care, improve patient outcomes, and reduce the burden on secondary and emergency healthcare services. PCES aim to provide more accessible, preventative, and proactive care, ensuring early diagnosis and effective management of health conditions. Investment in these services also enables a more effective primary care 'eco-system' and a GP workforce that is better able to respond to increasing pressure of demand.

Primary Care Enhanced Services in City & Hackney

Since April 2018 Enhanced Services in City & Hackney have been commissioned from primary care, either through the C&H Integrated Primary Care CIC or (in the case of Quality & Engagement) directly with the practices:

- Proactive Care – Home Visiting
- Proactive Care – Practice Based
- End of Life Care
- Mental Health Alliance
- Early Years
- Long Term Conditions
- Long Term Conditions (CYP)
- Duty Doctor
- Quality & Engagement*
- Community Anticoagulation

- Community Phlebotomy
- Community Wound Care
- Latent TB Screening

*Quality & Engagement (previously known as '*Clinical Commissioning & Engagement') has previously not been included in the PCES contract. Consideration is being given to how this might be incorporated into the contract framework from 2025.*

Since 2022 the following additional enhanced services have also been commissioned:

- Primary Care Stable Prostate Cancer Monitoring Service
- LTC and Prevention Contract - Cancer

Aims and Objectives

The Enhanced Services were designed to deliver high quality, equitable access and good value for money in line with national and local strategic priorities, including the North-East London Sustainability and Transformation Plan goal to "to develop new models of care to achieve better outcomes for all, focused on prevention and out-of-hospital care".

The overarching aim is to provide enhanced primary care services to improve health outcomes, reduce inequalities, and ensure sustainable delivery of high-quality care for the residents and patients in City & Hackney:

1. Deliver consistent, high-quality care that measurably improves patient outcomes, with a particular focus on reducing health inequalities affecting disadvantaged groups in the community.
2. Proactively identify and provide enhanced, targeted care for populations with greater health needs, including:
    a. People with long-term conditions
    b. Pregnant women and infants
    c. Individuals nearing end-of-life
    d. Those with serious mental illness
3. Expand access to both urgent and planned care services in community settings, bringing care closer to where patients live.
4. Alleviate pressure on hospital emergency and planned services through:
    a. Robust care planning
    b. Preventive care approaches
    c. Expanded community-based healthcare provision
5. Optimise utilisation of health system resources to maximise cost-effectiveness and value for money.
6. Strengthen the foundation for sustainable, high-quality primary care delivery in City & Hackney, building resilience to meet the community's evolving needs.

Key Outcomes and Value Added

Each of the services in the C&H PCES portfolio contributes to addressing and achieving these objectives; either through proactive care approaches, addressing urgent care needs, or improving access to services (or a combination of the above). Each service is robustly specified with Key Performance Indicators which have been met throughout the lifetime of the contract (notwithstanding where KPIs were waived and data not collected during the COVID-19 pandemic).

Taken as a whole, the Enhanced Services have created significant quality improvements across all the areas set out above - from ensuring timely access to urgent primary care needs via Duty Doctor and providing advance care planning for people with long term

conditions or approaching the end of life; to providing procedures like anticoagulation and wound care out of hospital and closer to home, as well as improving access to primary care services both across the board (C&H has the highest booked appointment rate per 1000 patients in NEL) and for patients in groups with the greatest health inequalities.

Primary care plays a vital role in healthcare provision and, at its best, is central to any aspiration to improve health and narrow inequalities. City & Hackney has the highest ratio of GPs to patients and a significantly lower rate of in-hours A&E activity compared to the rest of North East London. A significant proportion of the funding received by practices through PCES is reinvested into clinical workforce to enable them to deliver the activities outlined in the 13 service specifications. Sustained recurrent investment in these services over time has contributed to a more resilient and viable primary care workforce, with system benefits that extend beyond objectives and outcomes of the individual services into the overall quality and accessibility of primary medical services in City and Hackney.

These services and the associated strength of primary care in C&H have a major impact on activity levels in secondary care, with better planned and urgent access to primary care reducing the number of presentations at HHFT Emergency Department and PUCC and managing demand on referrals to secondary care, with City and Hackney lower rates lower than the NEL average post-pandemic despite Homerton Healthcare Foundation Trust recovering to deliver 98% of pre-pandemic GP referred first outpatient activity (which Barts and BHRUT have yet to do).

Further detail to be added subject to NEL Primary Care review, summarising financial cost-benefit of the services and comparisons with NEL

Contracting Framework
We are seeking approval to put in place a flexible framework for Primary Care Enhanced Services, focusing on outcomes and enabling appropriate flexibility and sustainability (as detailed in the 'Contracting' section below). This will enable us to take steps to add or vary specific services in accordance with changing context over the lifetime of the contract (for example, if national funding for activity becomes available which is best deployed locally in primary care, as has been the case with the TB Screening Service).

The current contract expires on 31 March 2025. This business case seeks approval to award a single contract on a 5+2 year basis, commencing on 1 April 2025, for the provision of the Enhanced Services described below, in order to deliver on the NEL ICS priorities for improving quality and outcomes and tackling health inequalities, and in alignment with the 6 cross-cutting themes under-pinning the ICS approach. The term of this proposed contract mirrors the framework in place for Tower Hamlets and Newham.

SECTION 2 – SCHEME OVERVIEW

City & Hackney Context
City & Hackney has a population of 347,969 (1.4.2024) served by 37 GP Practices. Some key challenges are:

- Second lowest healthy life expectancy (males and females) NEL (4.6 years less than the national average).
- City & Hackney is ethnically diverse (43% of population is non-white); with the second largest Black African and Caribbean population in NEL, as well as large

Turkish and Charedi communities. 24% of people have a first language other than English.
- Hackney is ranked 23rd most deprived out of the 312 local authority areas in England. 40% (117,000 of the population live in LSOAs ranked in the most deprived quintile; and 17.8% of children are in absolute low-income families).
- Hackney ranks lower than the national average for 8 out of the 12 national indicators for the prevention of ill-health.
- C&H has the highest prevalence of common mental disorders in NEL (24% compared to England average of 17%) and the highest prevalence of severe mental illness and inpatient stays in secondary MH services.

The Enhanced Services target a range of general and specific populations within City & Hackney and are fundamental to the place approach to addressing health inequalities. A key aim of the enhanced services is to deliver consistent, high-quality care that measurably improves patient outcomes, with a particular focus on reducing health inequalities affecting disadvantaged groups in the community, and providing enhanced, targeted care for populations with greater health needs (e.g. people with long-term conditions or with serious mental illness).

Overview of Services
This business case encompasses 13 Primary Care Enhanced Services, which provide a mixture of proactive patient identification and care, enhanced support for people with long term physical and mental health conditions, and improved access to urgent and planned care in community settings (while reducing pressure on emergency and planned services in hospital).

Taken as a whole, the services comprise a vital element of the local health eco-system and are instrumental in supporting the ongoing viability of both primary and secondary care provision in City & Hackney.

<u>GP End of Life Care</u>

- Supports improved identification and care planning for patients in the last years of life, to support more patients to receive care and to die in their preferred place; improve patients' and carers' experience of care in the last months of life and avoid unnecessary hospital admissions.

<u>Proactive Care – Home Visiting / Proactive Care – Practice Based</u>

- Provides personalised support to patients most at risk of unplanned admission, readmission, and A&E attendances, and or patients living with frailty to help them better manage their health.

<u>Latent TB Screening</u>

- Provides GPs education and support to increase uptake of IGRA testing in primary care and enables patients to be diagnosed and treated quickly for latent TB and other identified infections.
- Funding for this service comes from NHSE, and it is not yet clear that it will be continuing from Apr-25.

Early Years

- Aims to improve pregnancy outcomes and reduce maternal morbidity and mortality by offering targeted preconception advice antenatal and postnatal support to eligible women who are most at risk of poor outcomes in pregnancy and in the perinatal period.
- Vulnerable children and their families are also supported to access services and receive ongoing support through proactive action plans and regular reviews to ensure proper safeguarding processes are in place.

Long Term Conditions (Adults) / Long Term Conditions (Children and Young People)

- Proactive approaches to identify and provide holistic support for people with, or at risk of developing, Long Term Conditions; to optimise care and treatment; and enabling practices to embed efficiencies and best practice which benefit patients and the system as a whole.

Mental Health

- Commissions a diverse range of providers as a Primary Care Alliance to carry out a range of activities to improve the physical health of people with long term mental illness, reduce excess mortality, and provide a holistic gold standard of care.

Duty Doctor

- Same-Day Response to urgent primary care needs in City & Hackey. Additional GP capacity in each practice for a duty doctor to undertake GP same-day clinical triage of all urgent requests received by patients or their carer, with a call back within 2 hours; and a rapid GP response service to other health & social care professionals with an urgent request, with a call back within 30 minutes.

Community Anticoagulation

- Community-based service involving initiation and management of oral anticoagulation. Warfarin monitoring either face to face or home visit for INR management. Secondary care transfers of stable patients improving accessibility in line with national best practice.

Community Wound Care

- The service eases pressure on the Primary Urgent Care Centre (PUCC) at the Homerton by directing post-op wound care to primary care during core hours.

Community Phlebotomy

- Fast and local access for patients requiring routine or urgent blood collection, with improved accessibility and patient choice outside of core hours.

Primary Care Stable Prostate Cancer Monitoring Service

- Facilitation of transition of care for men with stable prostate cancer out of the acute hospital (Homerton only) setting and into primary care. Enhanced support for prostate cancer patients in the community including offer of annual holistic needs assessment and Prostate Specific Antigen (PSA) monitoring.

Long Term Conditions and Prevention - Cancer

- Embedding fast track cancer referral safety netting within all C&H GP practices to support early diagnosis and faster diagnostics and improve patient follow-up- and patient experience.

Quality & Engagement (*inclusion in framework contract to be confirmed*)

- Supports integrated system working and improved patient care through engaging practices in local secondary care demand management work (through a programme of review, audit, reflection and education). This is the only service within the business case that is contracted directly with practices, rather than through the Integrated Primary Care CIC.
- The overarching purpose of this contract is to engage practices in integrated system working and to improve quality of care for patients. This includes:
    - Engaging practices in *local secondary care demand management* work through reviewing the appropriateness of referrals, using advice and guidance where appropriate, secondary care feedback and other sources, attending pathway updates, audit, reflection on referral data and trends. This also encompasses the review of activity data relating to use of unplanned care services by registered patients
    - *Engagement with Place-based Partnership GP Education programme and significant meetings*, such as the Practitioner Forum, with subsequent dissemination of learning/information within the practice
    - Undertaking *Quality Improvement work* within practices
    - *Patient engagement and address inequalities* including promotion of Healthwatch patient engagement events, NEL winter campaign, Public Health campaigns and consultation with PPG on use of small practice improvement budget.
- The contract is also a useful vehicle for introducing pilots or one-off activities linked to current system strategic priorities, e.g. continuity related to the Fuller Programme, addressing environmental impacts of healthcare in primary care.

Objectives and Outcomes

The overarching aim of the proposal is to provide enhanced primary care services to improve health outcomes, reduce inequalities, and ensure sustainable delivery of high-quality care for the residents and patients in City & Hackney:

1. Deliver consistent, high-quality care that measurably improves patient outcomes, with a particular focus on reducing health inequalities affecting disadvantaged groups in the community.
2. Proactively identify and provide enhanced, targeted care for populations with greater health needs, including:
    a. People with long-term conditions

    b. Pregnant women and infants
    c. Individuals nearing end-of-life
    d. Those with serious mental illness
3. Expand access to both urgent and planned care services in community settings, bringing care closer to where patients live.
4. Alleviate pressure on hospital emergency and planned services through:
    a. Robust care planning
    b. Preventive care approaches
    c. Expanded community-based healthcare provision
5. Optimise utilisation of health system resources to maximise cost-effectiveness and value for money.
6. Strengthen the foundation for sustainable, high-quality primary care delivery in City & Hackney, building resilience to meet the community's evolving needs.

Each of the services in the C&H PCES portfolio contributes to addressing and achieving these objectives; either through proactive care approaches, addressing urgent care needs, or improving access to services (or a combination of the above).

Each of the 13 Enhanced Services has been robustly specified to deliver on key outcomes, and there is robust evidence on the delivery of those specific outcomes (data available on request). Key Performance Indicators for the individual services have been consistently met. The close working relationship between the ICB Place-based team and the Integrated Primary Care CIC enables us to develop and agree KPIs that have measurable outcomes and a unified approach to recording and reporting activity to support effective programme management. Details of how this is supported through target-setting, guidance and training, performance monitoring, RAG-rating, etc. are detailed in the Integrated Primary Care CIC Operating Model.

Some key outcomes are set out below as an indicator of the impact of Enhanced Services:

High-Quality care that Measurably Improves Patient Outcomes

- SMI Physical Health Checks – C&H has achieved the highest rate (80.2%) of patients with SMI receiving all 6 key physical healthchecks in NEL (Rest of NEL average - 68.7%)
- Duty Doctor – Over 99% of calls have received a response within 2 hours (calls for patients) or 30 minutes (calls from health and social care professionals). The average annual Duty Doctor call column is 100,000 calls from patients with an urgent need and 10,000 calls from professionals with an urgent need. Since the start of the contract, actual A&E attendances have reduced from a rate of 176 per 1,000 patients, to 160 per 1,000.
- Duty Doctor also rates highly in terms of patient experience. Quarterly audits are carried out including patient surveys. In 23-24 Q2, 93% of patients reported that they were satisfied (24%) or very satisfied (69%) with their appointment.
- End of Life Care Since the service began the % of APC-registered patients with an advance care plan in place has increased from 60% to 99%. City & Hackney has one of the highest % of people with an active Universal Care Plan in place in the country (more than x3 as many as the rest of NEL).
- Patient Experience – The 2022 annual Independent GP Patient Survey carried out by Ipsos Mori showed that of the 47 PCNs in North-East London, the 8 PCNs in City & Hackney performed well:

- % of patients saying their overall experience of their GP Practice was good: the top 5 NEL PCNs for satisfaction were C&H PCNs.
- Satisfaction with appointment offered: The top 6 NEL PCNs were C&H PCNs.
- Ease of getting through on the phone: The top 7 NEL PCNs were C&H PCNs.
- Confidence and trust in healthcare professional seen and spoken to: C&H 94% (compared to 89% for NEL)

Addressing Health Inequalities

- Proactive Care - 40% of patients supported under the Proactive Care Home Visiting (PCHV) service in 22/23 were within the NEL most deprived quintile. We know that people in lower socio-economic groups are more likely to have long-term health conditions, and these conditions tend to be more severe. Deprivation also increases the likelihood of having more than one long-term condition at the same time, and on average people in the most deprived fifth of the population develop multiple long-term conditions 10 years earlier than those in the least deprived fifth. In 22/23, 63% of patients supported under the PCHV had 3 or more long term conditions.
- Long Term Conditions service includes ring-fenced budget to address health inequalities through targeted interventions, actively seeking to engage under-served populations and key demographics (e.g. housebound patients). In 2023/24 practices implemented a range of "change ideas" to improve the number of housebound patients who benefit from the full diabetes annual review; and the number of black patients whose blood pressure is under control and who are on a statin. This work focusses on populations known to have worse clinical outcomes with usual care. Practices came up with a range of ideas including engagement events, dedicated phonecalls to" at risk" patients to agree an individualised approach to managing their health and dedicated admin and clinical staff to visit patients at home.
- The Early Years contract is crucial to a collaborative approach to supporting our most vulnerable pregnant women and ensuring better outcomes; and the GP-led Perinatal Mental Health Taskforce is focused on improving awareness, accessibility and referrals to appropriate support, and enabling a holistic approach to women during the perinatal period.

Proactive and Preventative Approaches

- Anticoagulation - Better regulation of anticoagulation in patients with Atrial Fibrilation reduces morbidity and mortality e.g. Warfarin/DOACs reduces the risk of a stroke in atrial fibrillation by approximately 65%
- Latent TB Screening - Early diagnosis and treatment for latent TB,
- Long Term Conditions - proactive identification of people at risk of developing an LTC such as diabetes, heart disease or respiratory conditions. A study by the University of Oxford and Diabetes UK1 showed that those who met their diabetes treatment targets lowered their risk of developing diabetes-related complications by £1,037 per person. The research also showed that meeting all three treatment targets leads to an additional 1.5 years of healthy life per person due to a reduced risk of complications. Further studies by Kidney Research UK indicate that the cost of such interventions are significantly lower than the costs of care.

[1] Achieving Type 2 diabetes treatment targets would improve health and reduce healthcare costs — Health Economics Research Centre (HERC) (ox.ac.uk)

- Serious Mental Illness Healthchecks – City & Hackney is the top performer in North East London for SMI health checks, and performing at 80%, which above the national target, in spite of having a large number of patients on the SMI register.

Expand access to both urgent and planned care services in community settings

- Primary Care in City & Hackney offers the highest weekly total booked appointment rate per 1000 patients in North East London (City & Hackney – 435; NEL – 369; London – 370; England – 438). Data from the GP Patient Survey (an annual England-wide survey about patients' experiences of their GP practice) consistently says that patients in City & Hackney are happy with access. This is likely to be influenced by having a robust and effective Duty Doctor and other enhanced services commissioned for C&H registered population.
- Long Term Conditions – The "Time to Talk" schedule in the LTC Contract offers patients with multiple Long Term Conditions the opportunity to have a 30 min consultation with a health care professional to discuss wider issues that may be impacting their health and well-being (such as money worries or relationship issues). In 2023/24, 11,199 consultations took place. Carers are also eligible for the scheme, as are patients with Sickle Cell Disease with or without another condition.
- Community based services – Anticoagulation: In 2023/24 240 Warfarin patients were managed in primary care. Activity includes 3,796 POCT INR tests and 465 home visits. All 37 practices in C&H now provide phlebotomy services, and activity now covers 90% of all primary care requests for pathology.
- Improving equitable access to services is essential to reducing health inequalities. The Clinical Commissioning and Engagement contract contains an equalities domain that requires practices to consistently reflect on the accessibility of their services to patients requiring interpretation. For 24/25 it also includes a requirement to gain local Autism Friendly accreditation through completion of a checklist to identify and implement changes to make their practice more accessible for autistic people.

Alleviating Pressure on Secondary Care Urgent and Planned Services

- Services currently in place have a significant impact on secondary care activity. Considerable impact would be seen if services were not recommissioned *(*as, for example, poorly managed Long-Term Conditions would result in more disease complications at an earlier age and an increase in heart attacks, strokes, diabetic ketoacidosis, leg ulcers, amputations and kidney disease).
    - As an example, in 2023/24, analysis from the Eclipse database of City and Hackney patients, showed that people with diabetes who had all 8 care processes completed, cost the system on average £140 in unplanned care costs; compared to £408 average cost for those with fewer than 4 care processes (patients were of a similar age and frailty level).
- End of Life Care - Over the lifetime of the contract, there has been a 12% reduction in the number of hospital deaths of people aged 75-84, and a 16% reduction in people aged 85+. In 2022 City & Hackney had the lowest % of deaths in hospital for people aged 75-84 in North-East London, and the second highest % of deaths at home for the same age group.
- Duty Doctor - In quarter 2 of 23/24 GP Practices undertook an annual deep dive audit which looked in detail at calls to Duty Doctor from calls from Health care

Professionals and calls from patients. The audit found that 74% of Duty Doctor interventions prevented a secondary care attendance. City & Hackney has the lowest in-hours rate for A&E/UTC attendances in North-East London.

- Anticoagulation – Since 2019, 137 stable warfarin patients have been successfully transferred from secondary care to primary care anticoagulation centres, reducing clinic burdens in hospital and improving accessibility in primary care. Since 2017, there have been 554 DOAC initiations in primary care anticoagulation centres (including switching from warfarin and from AF diagnosis) which would have otherwise taken place in HHFT anticoagulation clinic.
- Post-operative wound care and Phlebotomy - services delivered by Primary Care in the community provided 122,731 blood tests and 7,992 wound care contacts within 2023/24 which would otherwise have taken place in HHFT. There has been a 56% decrease in wound care attendances from C&H registered patients at PUCC 2023-24 compared to 2016 when the contract began.
- Quality & Engagement – Engagement of practices in local secondary care demand management work (through discussion of referrals prior to them being made, audits, reflective practice and adherence to local pathways) has had a significant impact. Review of SUS data for GP-referred first outpatient attendances since 2019 confirms the historically low referral activity, with City and Hackney lower rates lower than the NEL average post-pandemic despite Homerton Healthcare Foundation Trust recovering to deliver 98% of pre-pandemic GP referred first outpatient activity (which Barts and BHRUT have yet to do).
- Serious Mental Illness Healthchecks and Mental Health Alliance Approaches - Improving LTC management and health in our SMI patients and patients suffering from depression ensures less need for secondary care physical health services. NHSE estimate that untreated depression in people with diabetes increases care needs by 50%. Having comprehensive voluntary sector support for people with mental ill health also means that we are assisting our provider colleagues who are under pressure with increasing mental health need.

Optimise Utilisation of Health-System Resources to Maximise Cost-Effectiveness

- Proactive Care - In 2023 the NHS NEL Intelligence and Insights Team carried out analysis comparing patients on the C&H Proactive Care Scheme with patients with similar patients from other boroughs where such a scheme was not in place. The data findings suggested that over a 2-year period, £1.6m in secondary care costs could be saved per 1,000 patients.
- Long Term Conditions – It is estimated that over the next 5 years the adult Long Term Conditions service will reduce acute costs associated with strokes, heart attacks, COPD readmissions and first outpatient appointments by £10.7m.
- Duty Doctor provides practice-based responses to urgent primary care need which limits A&E attendance and admissions. Cost benefit analysis of Duty Doctor indicated that the service has prevented additional annual costs in UEC averaging £11.3m (£9.6m p/a after service costs).
- Cost per Patient - Over the lifetime of the contract, the provider has absorbed considerable pressure from rising list size and inflation of costs, which have only been partially offset by annual uplifts. Since the contract began in 2018/19, the list size of registered patients in City & Hackney has increased by 7.9% (from 322,456 to 348,000). The average cost per patient for GP Enhanced Services in City &

Hackney has reduced over the same period, from £33.57 to £32.40. If costs had tracked inflation the 23/24 cost would be £39.20 per patient.

- Uplifts amounting to £835,615 have been applied to the contract since it was launched in 2018/19. This is a funding increase of 7.71% of the original value. Actual inflation over the same period (according to the Bank of England inflation calculator) has been 26%.

Further content to be added, relating to affordability and value for money (taking into consideration NEL context and quantitative data from ED, LAS Demand, SUS, etc.) – potentially stating an overall cost-benefit for PCES

Strengthen the Foundation for Sustainable, High-Quality Primary Care Delivery in City & Hackney

- National analysis of the GP patient survey reveals that patients are finding it harder to get appointments and turning to A&E for basic care needs. In 2021, 7.6 per cent of those who couldn't get appointments said they went to A&E because they couldn't see a GP - the equivalent of 282,000 people. In 2023 that figure was 12.2 per cent, the equivalent of 696,000, a rise of 146%. Primary care plays a vital role in healthcare provision and, at its best, is central to any aspiration to improve health and narrow inequalities. Yet, this new data shows that patients are finding it difficult to get GP appointments and are increasingly turning to already overstretched A&E departments to get care, particularly patients living in the most deprived parts of England.
- Analysis of primary care workforce (*NHS England GP Workforce Heatmap Project*) shows that while overall North-East London has 1 GP per 2,894 patients, the ratio in City & Hackney is 1:2,085 (8th best out of the 32 boroughs). At the same time, C&H has a significantly lower rate of in-hours A&E activity than the rest of NEL.

Location		Total Score	Rank
North East London ICB		41	1
North West London ICB		42	2
South East London ICB		42	2
North Central London		46	4
South West London ICB		54	5
NEL	Waltham Forest	165	1
NEL	Redbridge	184	2
NEL	Havering	194	3
NEL	Barking and Dagenham	195	4
NWL	Hillingdon	205	5
NCL	Enfield	208	6
NWL	Brent	214	7
NEL	Newham	220	8
NWL	Ealing	232	9
SEL	Lewisham	232	9
SEL	Greenwich	233	11
NWL	Hounslow	244	12
SEL	Bexley	257	13
NWL	Harrow	261	14
SWL	Croydon	263	15
NCL	Barnet	280	16
SEL	Southwark	285	17
NCL	Haringey	285	17
NCL	Islington	285	17
SEL	Bromley	306	20
SWL	Sutton	314	21
NEL	Tower Hamlets	320	22
NWL	Hammersmith and Fulham	324	23
SEL	Lambeth	331	24
NEL	Hackney and City of Londc	338	25
NWL	Kensington and Chelsea	340	26
SWL	Merton	346	27
SWL	Richmond upon Thames	347	28
NCL	Camden	376	29
NWL	Westminster	377	30
SWL	Wandsworth	379	31
SWL	Kingston upon Thames	401	32

- We know that a significant proportion of the funding received by practices through PCES is reinvested into clinical workforce to enable them to deliver the activities outlined in the 13 service specifications. From this perspective sustained recurrent investment in these services over time has contributed to a more resilient and viable primary care workforce than in other parts of NEL and the region, with system benefits that extend beyond objectives and outcomes of the individual services into the overall quality and accessibility of primary medical services in City and Hackney.
- Provision of services through primary care also has the added-value effect of ensuring that the primary care workforce in City & Hackney is trained-up in areas such as wound care and end of life care.
- More broadly, investment in PCES supports the growth and sustainability of the voluntary and community sector in C&H. Mental health transformation work has been centred around providing care for the social determinants of poor mental health, and we have led this work locally through our Alliance arrangements ensuring strong voluntary sector involvement, developing active pathways from primary care into the Community via Core Sport, Well Family and Volunteer Centre Hackney.
- Several activities in the Clinical Commissioning and Engagement contract, around referral discussion, case review, audit and dissemination of information from GP education are also perceived to helped City and Hackney practices with GP satisfaction and retention. A 2018 Public Health evaluation of that contract undertook interviews with practice staff, with several GPs commenting that the “positive culture set by the contract as a result of the behaviours that it encouraged” as being important in their decision to stay in the area. This line of enquiry during the interviews was based on a theme in the supporting literature review establishing a link between GP satisfaction and professional support, opportunities to broaden clinical understanding, discuss and plan work with colleagues within the practice.

Alignment with Strategic Priorities

The City & Hackney Primary Care Enhanced Services support delivery against the NHS Long Term Plan, NHS Outcomes Framework, and the North-East London ICB System Priorities of improving quality and outcomes, and tackling health inequalities relating to Babies, Children and Young People, Long Term Conditions, Mental Health and Workforce.

The Services also support the 6 cross-cutting themes of:

- Tackling 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

Additionally, individual schemes align with the following:

- NHS North-East London Palliative and End of Life Care Strategy, 2023
- Major Conditions Strategy

- NEL Same Day Access work
- NEL Fuller Programme
- NEL Urgent and Emergency Care Workstream
- NEL Primary Care Workstream
- NHS England National Maternity Programme Priorities

Overlap with North-East London Activity
This proposal to extend contracting arrangements for Enhanced Services covers City & Hackney Place and is not NEL-wide. It marks a continuation of Primary Care strategy, development and delivery over the last 10 years. Individual services are integrated in planning and activity at NEL level, however.

The following services have particular relationships with work going on across the ICB:

- Anticoagulation - A NEL review of all Anticoagulation services is currently underway and is likely to conclude in early 2025 City & Hackney is the only place that has a unique primary care anticoagulation service already in place, with anticoagulation centres initiating and monitoring warfarin, initiating DOACs, carrying out home visits and accepting warfarin patients from secondary care.
- Long Term Conditions - aligns with the NEL LTC outcomes framework work. The ambition is to dovetail developments at NEL level into the annual iteration of the contract review. This work has already started with a review of the current indicators and seeking ways to align them more closely with the NEL framework. Each place in NEL has Long Term Conditions work in progress, delivered via a range of providers, and each place is working towards aligning their LTC contract or equivalent more closely to the NEL LTC outcomes framework.
- Duty Doctor is aligned with the NEL Same Day Access to Primary Care programme, which is currently ongoing. Duty Doctor follows a different model to provision in the rest of NEL (the NEL Local Enhanced Service Equalisation Programme in 2022 supported the business case to commission Duty Doctor NEL wide, but this was unable to progress due to insufficient funding) but is aligned with the delivery principles and C&H are part of the ongoing programme of development.

Risks of not Re-commissioning Services

There are a number of very significant risks and issues that would arise if a decision were made not to progress with re-commissioning of the Primary Care Enhanced Services in City & Hackney:

- If we fail to commission proactive provision for patients with LTCs, SMIs, at End of Life or at risk of deterioration and unwarranted health outcomes, patients' health, happiness and independence will suffer and they will deteriorate at a greater rate than if they had received appropriate levels of support.
- The long-term investment in primary care provided by this contract is essential to the financial stability and viability of practices in City & Hackney. The additional resources provided by the primary care enhanced service contracts funds permanent GP practice staff that are responsible for delivering on the contract KPIs. Withdrawal of this funding would create a crisis in primary care and undermine its delivery of quality care for residents.

- We would see major increase in avoidable admissions and A&E attendances as poorly managed LTCs result in more disease complications at an earlier age and an increase in avoidable serious medical conditions. We would expect there to be significant additional pressures for Homerton Healthcare, East London Foundation Trust as well as care services provided by the local authority.
- Similarly, if Duty Doctor was not continued, we would see an immediate very large increase in A&E attendances from people needing same-day access to urgent primary care. This would be likely to lead to poor experiences for the patient and worse outcomes than if they had been supported out of hospital, as well as unsustainable levels of demand and costs in secondary care.

Contracting

Flexible Framework Model Contract

The new iteration of the ICB extended service contract with the Integrated primary care provider which will succeed the Integrated Primary Care CIC will be commissioned using a flexible framework model. The form of contract will be created to provide flexibility to add, remove or change elements of primary care extended services during the term of the contract thereby making it unnecessary to issue additional contracts to the provider or to PCNs during the current term.

The flexible framework model was implemented successfully in Tower Hamlets and Newham, over a 5-year initial term, where PCNs were the contracted provider of choice for those places. The City & Hackney version of the flexible framework will instead have the City and Hackney Integrated Primary Care CIC as the contracted provider of choice. There appear to be benefits from contracting in a way that allows inherent flexibility to commission additional extended services through the same contract i.e. governance, working relationships and established monitoring arrangements can be carried over to additional services, and new services can be added through contract variations (allowable modifications under the Provider Selection Regime) without the need for competitive tendering or the creation of new contracts / Memoranda of Understanding.

The current portfolio of extended services in C&H are all clinical services however the new C&H flexible framework contract will be created to allow an option for practice development activities; such as QI, PCN development, and modernising general practice, to be added later. The flexible framework model will also allow for changes to clinical service to be added during the contract such as the implementation of the NEL LTC framework.

BUSINESS CASE TO BE INCORPORATED INTO NORTH EAST LONDON ENHANCED SERVICES PAPER BEING PREPARED BY NEL PRIMARY CARE TEAM.

This will include:

- **expanded section on economic case to be made in context of NEL;**
- **details of commercial approach to be taken (contracts and procurement);**

- **full details of financial investment value (incl. corporate overheads and costs)**
- **Management considerations – stakeholder and resident engagement in development of proposals, timelines, etc**

City & Hackney Health and Care Board

13 November 2024

Title of report	City and Hackney Winter Plan 2024/25
Author	Anna Hanbury, Head of Age Well
Presented by	Anna Hanbury, Head of Age Well
Contact for further information	Anna Hanbury
Executive summary	Each year, partners across the City and Hackney system work together to support winter preparedness across the health and care system. The continued high levels of demand across the system, GP Collective Action as well as the potential for further peaks of CoVID 19 and other seasonal viruses in the context of the cost-of-living crisis mean that this winter could bring unprecedented challenges. This paper presents the City and Hackney Health and Care Board: **Key features of our winter planning approach** • Partnership system plan – includes input from a wide range of system partners and considers winter across all our programmes of work • Focus on prevention – keeping people well, admission avoidance and alternatives to UEC as well as acute flow and capacity • Driven by our local system needs, rather than criteria set by NHSE • Considers wider community-based support – beyond just admission avoidance or discharge • Includes process to monitor and manage pressure in the system over winter **National context and requirements** • Delivery of year two of UEC recovery plan with continued focus on the high impact interventions • System working supported by clear partner roles and responsibilities **Elements of our plan** • **Core partnership action plan** – - Actions across all programmes to mitigate key risks identified (and addressing NHSE high impact initiatives)

	- Focus on prevention, community alternatives to UEC, optimising flow • **Winter resilience schemes** - NHSE/DHSC funded discharge, demand and capacity initiatives • **Ongoing monitoring / Escalation process** - Process to monitor and manage pressure in the system over winter
Action / recommendation	The Board/Committee is asked to: -Endorse proposed City and Hackney Winter plan -Consider whether any further actions required to support system resilience -Note / endorse next steps for ongoing management of the winter plan – responding to emerging pressures (and further resilience funding
Previous reporting	**Discharge Fund** (part of BCF Plans) • City & Hackney Health and Care Board – 8/05/2024 • City & Hackney Neighbourhood Health and Care Board – 2/05/2024 (virtual) • Hackney Better Care Fund Partnership Group – 30/04/2024 • Hackney Health & Wellbeing Board - 26/07/2024 • City of London Health and Wellbeing Board –13/09/2024 **Physical capacity** • City and Hackney Delivery Group 17/07 & 8/08/2024 • City and Hackney Health and Care Board –21/08/2024 (virtual)
Next steps/ onward reporting	City & Hackney PbP Delivery Group 14/11/24 City and Hackney Neighbourhood Health and Care Board 26/11/24 NEL UEC Delivery Group & NEL UEC Programme Board – as requested
Conflicts of interest	Nil
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access
Impact on local people, health inequalities and sustainability	C&H System Winter Plan - Supports vulnerable cohorts to stay well and avoid crisis over winter - Supports health and social care services to manage the increased pressures over winter so that patients can continue to receive quality care if they need it Physical Capacity and Discharge Funding plans:

	- The discharge funds will enable more people to be discharged to an appropriate setting. - It will also support mental health clients being discharged from acute mental health units. - The physical capacity elements of funding will strengthen the Homerton and East London Foundation Trust in terms of general demand throughout the year, rather than just over winter, recognising the pressures are no longer seasonal. This is short term funding so will not address sustainability requirements but there may be future funding built into the Better Care Fund for this purpose.
Has an Equalities Impact Assessment been carried out?	An equalities impact assessment has not been undertaken. The schemes are not generally new but are expanding on current system capacity.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report. The winter resilience schemes are funded from national monies allocated.
Risks	Winter resilience proposal addresses key system risks around predicted winter pressures There are risks to delivery of some resilience schemes because of workforce challenges. Sustainability The discharge and physical capacity funding is non recurrent which presents a sustainability risk. This risk has been highlighted in the UEC financial review that is underway with an ask that the ICB confirm a commitment to longer term funding of the schemes with evidenced impact.

City and Hackney Winter Plan 2023/24

Introduction

Each year, partners across the City and Hackney system work together to support winter preparedness across the health and care system.

The continued high levels of demand across the system, GP collective action as well as the potential for further peaks of CoVID 19 and other seasonal illnesses in the context of the cost-of-living crisis mean that this winter could bring unprecedented challenges.

Our winter planning takes a system approach to minimising the risks from winter with oversight from our Placed based Partnership Delivery Group.

Purpose

To present the City and Hackney Winter Plan 2024/25 to the City and Hackney Health and Care Board, including.

- Planning process / approach
- National context and requirements - including discharge and physical capacity funding
- Individual elements of the plan – core action, winter resilience schemes & escalation process

The Board are asked to

- Endorse the proposed winter plan
- Consider whether any further actions are required to ensure the plan supports the system to manage the pressures it will face in the coming months

Winter Planning Process

The key features of our winter planning process:

- Partnership system plan – includes input from a wide range of system partners and considers winter across all our programmes of work rather than a standalone exercise with UEC partners
- Focuses on admission avoidance, discharge and community services as well as acute capacity
- Driven by our local system needs
- Considers wider community-based support – beyond just admission avoidance or discharge
- Incorporates readiness for peaks in CoVID and other febrile respiratory conditions
- Considers process to monitor and manage pressure in the system over winter

National context and requirements

Preparation for winter has been supported by broader strategic and operational plans including the Delivery Plan for recovering Urgent and Emergency Care services which is now in year two (UEC recovery plan - January 2023).

NHSE and the Department of Health and Social Care have set out priorities for Winter 2024-25 and key steps to meet the challenges ahead.

This includes an ask for systems to continue to deliver on the UEC recovery plan and the high impact interventions within it.

Delivering the NHSE winter priorities are not the basis or entirety of our winter plan, but we will ensure that our collective actions cover the high impact interventions and other actions set out as well as respond to local needs.

As part of NEL, we are required to respond to NHSE as part of the national assurance process.

Elements of our winter plan

Our winter 'plan' is more than a single detailed plan for winter and consists of the following elements.

- **Core partnership action plan**
  - Actions across all programmes to mitigate key risks identified
  - Support the following
    - **vulnerable people to stay well and avoid crisis** through the winter
    - A reduction in demand on acute hospital beds – either through **admission avoidance or expediting discharge**
    - **Flow through and out of the hospital setting**
    - A **reduction in demand on other out of hospital services** that are particularly pressured, or expect to be pressured, such as primary care
    - **Sustainability of a service** through pressured winter months
  -
- **Winter resilience schemes**
  - NHSE/DHSC funded discharge, and physical capacity initiatives
- **Escalation process**
  - Process to monitor and manage pressure in the system over winter

The following sections of this paper describe each of these elements in more detail.

Core action plan

This part of the plan has been developed in a similar way to previous years, setting out the key risks and opportunities that partners have identified from each of their individual areas describing where these are being addressed and identifying any challenges.

The NHSE high impact interventions have been considered as part of this process.

Some of these actions sit within single organisations, some are a responsibility of partners within the City and Hackney system, and some are NEL or even London-wide.

Partners have worked on their individual areas with collection actions described against the following three focus areas

- Keeping people well in the community (prevention and alternative pathways)

- Acute readiness, optimising capacity and flow
- Discharge and community, optimising capacity and maximising safe timely discharge from hospital

The Age Well team have co-ordinated this process and have collated actions into a comprehensive plan.

The core plan is attached as appendix A for reference – to note this is a live document which can be revised in response to new risks and pressures as they emerge.

Winter Resilience schemes

NHSE & DHSC funding

In 2022-23 NHSE committed monies to fund systems to increase acute bed capacity through additional beds or reduced usage via admission avoidance or expedited discharge. There was also additional funding to support social care to speed up discharge over the winter period (Adult Social Care Discharge Funding – ASCDF).

In 2023-24 the national focus on hospital flow and discharge continued together with discharge funding to support social care to speed up discharge from hospital. Discharge funding was integrated into the Better Care Fund for two years to enable local areas to build additional capacity in adult social care and community based reablement.

In addition to this, ICBs also received dedicated funding to deliver increased capacity in urgent and emergency services (and wider objectives of the recovery plan) as part of operational planning for 2023/2024. This ICB 'Physical Capacity' funding was received again for 2024/25 with Place allocations confirmed in August 2024.

The funding streams are set out below:

Funding	Hackney Allocation 23/24:	Hackney Allocation 24/25*:	City Allocation 23/24:	City Allocation 24/25*:
Local Authority Discharge Fund	£2,332,000	£3,871,120	£45,376	£74,700
ICB Discharge Fund	£1,103,268	£2,105,663	£4,181	£8,881
	City and Hackney 2023/24		**City and Hackney 24/25**	
Physical Capacity	Homerton £1,611,922 East London Foundation Trust £277,023		Homerton £1,709,000 Place allocation £686,884 – (includes ELFT and other providers)	

City and Hackney approach to developing funding plans

- The Discharge steering group and the BCF partnership group have oversight of planning and delivery of schemes funded by Discharge monies
- The physical capacity plans were developed by resilience group with broad partnership representation including Homerton (acute & community), ELFT (MH), Primary Care and Local Authority. Support and co-ordination provided by ICB programme leads who also linked with voluntary sector where appropriate.
- Through these groups, partners reviewed the impact of previous funded schemes together with current system pressures to inform proposals for 2024/25.
- Discharge and physical capacity plans were endorsed by the PbP Delivery Group, Neighbourhood Health and Care Board and City and Hackney Health and Care Board in August 2024.
- Our place physical capacity plans were incorporated into a single NEL business case that was presented to IRG in October 2024. A collection of individual schemes across all Places were challenged due to insufficient strength of evidenced impact on capacity and were not approved. However, we were given a short opportunity to submit a revised bid to address a critical pressure in our discharge pathway with additional resource in our integrated discharge team. This was approved on the 1/11/2024.
- A small winter planning group with membership from the Age Well team, Local Authority, Homerton, ELFT and Primary Care is being established to oversee ongoing delivery of these schemes. This will include meeting national and local reporting requirements and assessment of impact.
- This group will also have a role in co-ordination and oversight of the wider winter plan for C&H.
- A full list of proposals is attached in Appendix B.

Ongoing monitoring and escalation process

It is proposed that an escalation process be agreed to monitor and manage pressure in the system over the winter months with the following key features
:

- Monthly review of system pressure (and oversight of core plan) by PbP Delivery Group (DG).
- Additional actions that can be implemented in response to increasing pressure in the system triggered by:
  - DG – following monthly review of system pressure
  - Key partners in the system at any time
- System escalation group
  - Representation from Homerton, Local authority, Mental Health, Primary care & system

- Meets bi-weekly to review system pressure
- Convened more regularly in response to increasing pressure – manages escalation actions
- Meets daily during periods of increased pressure
- Reports into DG to maintain oversight

Next steps

- Confirm membership for C&H winter resilience group
  - Agree local monitoring of national funded winter resilience schemes
- Ongoing reporting to C&H Delivery Group
- Feed into NEL ICS winter resilience plan and process – responding to NHSE assurance as required

Conclusion / recommendations

The Board are asked to

- Endorse the winter plan and ongoing oversight and escalation
- Consider whether any further actions are required to ensure the plan supports the system to manage the pressures it will face in the coming months

Anna Hanbury November 2024

Appendix A

CITY & HACKNEY PLACE BASED PARTNERSHIP 2024/25 WINTER PLAN	
Focus: **Keeping People well & at home (prevention & alternative pathways)**	
Challenges	**Support In Place**
Demand - predicted higher than previous years, significant in primary care due to vaccination programme Workforce - current workforce exhausted, lack of available workforce to recruit into new roles / schemes Cost of living - pressure on residents/patients with potential impact on health and providers with potential risk of failure	**Urgent primary care pathways and capacity** - Continued commissioning of additional GP capacity to support UEC and mitigate gap with transition from GP hubs to enhanced access PCN DES - Promotion of Duty Doctor (DD)for managing urgent primary care demand during core hours - dashboard of A&E attendance rate during core hours by practice, IPC support to practices to maximise utilisation of DD -Primary Care - ED T&F group established to identify opportunities for optimising demand management between primary and secondary care (supporting GPs to maximise management within primary care with advice and guidance as well as direct referral to SDEC or speciality if appropriate) - Primary care education events - utilising scheduled learning sessions for targeted training prior to winter e.g. urgent care pathways, managing frailty, paediatrics
	Proactive Care - Proactive care pathway – *ageing well* this service provides a proactive and joined up approach to supporting C&H residents with rising needs. Delivered by Occupational Therapists and Care Coordinators at PCN level in collaboration with ACRT at Homerton, for patients who have mild to moderate frailty Proactive Care Home Visiting & Practice Based Service - Additional funding to increase capacity in line with increase in number of housebound patients in need of this service

Continuing to maximise use of community pharmacies as part of integrated pathways – redirection of patients to more appropriate sources of help and support - NEL Community Pharmacy Selfcare Advice Service can provide alternative capacity to GP – including free over the counter items and advice for eligible patients. (by referral only) - improving referral pathway from practices and 111 to Pharmacy First (minor illness/clinical pathway) service via Local Service on EMIS - Increasing patient awareness, understanding and confidence in clinical expertise available in pharmacies; information available here***:*** ***https://northeastlondon.icb.nhs.uk/health-services/pharmacy/***
Pharmacy schemes supporting primary care recovery & wider (winter) resilience Electronic repeat dispensing BP Case finding and ABPMs Contraceptive services launching in NEL 25th November 2024 Discharge Medicines services Community Pharmacy Independent Prescribing pilot
Strengthened provision and access to - 2-hour community crisis response – 8-8 7 days week, 9 clinical conditions - robust delivery of 2-hour standard from our crisis response services - strengthened capacity of teams, winter resilience workforce planning underway -Operational review of Paradoc to identify opportunity to maximise benefit delivered -Streamlined operational management of urgent community provision (IIT rapid response & Paradoc) to support co-ordinated MDT response - initiatives to maximise access and referral from all sources: Review & streamlining access / referral pathway – electronic booking, DoS review, working to deliver key criteria for single point of access (SPOA) set out by NHSE Comms to improve awareness and understanding of UCR capability – LAS, telecare, care homes Promotions of direct referral from Telecare & care homes UCR services Direct electronic booking from 111 - Paradoc

	Virtual wards and community pathways ARI, Frailty and Heart Failure virtual wards in place - building on existing services and pathways to increase capacity to care for people in their own homes. -40 ARI, 20 Heart failure, 26 Frailty -Work to integrate with provision with other urgent community services to maximise utilisation and impact - Patient and clinician engagement and communication to maximise appropriate utilisation - Review of current in-patient admissions to identify missed opportunity -Exploring scope for introduction of remote technology and point of care testing to increase capacity and or acuity of patient safely managed on virtual ward
	Access to specialist advice in the community – Primary / Secondary care interface Primary and secondary care pathways and communication agreed to support shared management of demand (and facilitate appropriate navigation from 111) A&E Audit – practice review of A&E attends to explore opportunities for improved management -Developing urgent care website for GPs - clear information on full range of services/pathways available with referral route incl. direct referral to speciality - Review and refresh of all urgent care pathways - targeted education events to support - optimal use of urgent and emergency services - management of complexity & conditions more likely to present in winter
	Children Young People and Families - Introducing a modified pathway for bringing professionals together for LDA crisis presentations – focus on trying to reduce these unplanned admissions - Development of a UEC escalation grid with named points of escalation across agencies to support urgent response - Reviewing roles and responsibilities between ICB central & BCYP team to ensure co-ordinated response supported by NHSE reporting
	Ongoing initiatives to support cost of living pressures for residents *Cold weather packs for vulnerable cohorts – Age Uk* Winter Communication campaign - improve understanding and awareness of services to help people choosing wisely

Focus: Acute readiness, front door & flow	
Challenges	**Support In Place**
Demand – higher and more complex than previous years causing increased pressure on beds and longer waits in A&E Mental Health - Increase in demand and complexity of cases with longer LoS exacerbating demand capacity mismatch -> significant issue in A&E Workforce - current workforce exhausted, lack of available workforce to recruit into new roles / schemes, Industrial action	**Homerton winter planning process in place to support all elements of acute care** - capacity, escalation, workforce planning, maintaining flow
	NHSE funded physical capacity schemes - **Homerton** 20 'escalation' beds on Defoe Resources to support rate limiting functions – domestic cleaners, eco-lab, transport Additional resource in discharge teams & site flow management (CSM, Flow co-Ordinator, CHC) Maximising utilisation / impact from front door alternatives – SDEC (Hamu) in reach, **ELFT** Additional resource in discharge teams Housing discharge fund – step down / crisis beds for MH
	Geriatrician at the front door - Named Geriatrician for each day Monday- Friday service -- Attends ED majors/ OMU and facilitate discharge alongside IIT - Work to enhance this provision & integrate with community frailty services and emerging Frailty ward
	SDEC Maximising utilisation of SDEC; return to previous location, name change to SDEC, direct telephone access to SDEC consultant, promotion of service to key partners to maximise referral
	Primary – Secondary care interface Work to identify gaps and opportunities for collaborative working to supporting most appropriate management of patient need – away from A&E where possible
	NEL Mental Health Improvement Network – broad programme underway to improve Mental Health UEC and Crisis pathways Range of projects underway

Focus: Discharge & community	
Challenges	**Support In Place**
Homerton has a strong track record of delivering good performance through winter however recent years have presented significant challenges with extreme pressure on G&A capacity	**Discharge improvement programme** – independent review of discharge pathway in C&H (2023) identified improvement opportunities - Transforming outcomes programme currently being delivered by Newton Europe for LBH - includes 'acute discharge' workstream - Joint transformation plan being developed that brings together the recommendations from both reviews and Homerton priorities - Joint transformation delivery group focussed on actions to support resilience over winter – with a focus on those linked to 'Care transfer hubs' as a high impact intervention
There has been an increase in discharge delays recently with an increased % G & A beds occupied by patients who are medically fit for discharge. This is caused by several factors – demand, capacity, complexity and workforce that are difficult to address with a risk of further deterioration	**Integrated Discharge Service/hub** Manages both Homerton and out of borough hospital discharges through twice daily MDT meetings to review all patients who no longer meet the criteria to reside in an acute bed are considered discharge ready. Improvements in pathways and process to enable this service to manage predicted high levels of demand through winter. - review of current performance has been undertaken with targets set for acceptable timeframes within the pathway to support improved performance -enhanced senior support early in pathway (at referral) to support IDS team decision making, Mental Health - work to map existing pathways and teams – exploring opportunity for closer working with IDS to support discharge from MH trusts **City of London** - City are monitoring market capacity and have spot purchase arrangements in place to support when necessary - Care navigator is based on hospital wards and co-ordinates with hospital discharge teams to undertake early discharge planning utilizing spot purchased care provision. - A Rapid Response service facilitates hospital discharge by care navigator is based on hospital wards and co-ordinates with hospital discharge teams to undertake early discharge planning. providing up to 72 hours of assessment and then onward pathway

Increase complexity of patients and cost of care	**Physical capacity and discharge funded schemes** - additional step-down community capacity - Nursing home, Housing with Care (supported housing) - Increased resource in discharge teams to support flow across 7 days: - Medical & nursing, therapies, pharmacy, discharge co-ordinators, transport (as above) - SW, brokerage, VCS - take-home & settle, and equipment - Mental health – step down capacity and increased resource in MH discharge team
	Homeless discharge team in place with 6-bed accommodation – for step-up/step down support for homeless people
	Pharmacy Implementation of NHSE commissioned Discharge Medicines Service
Vaccine hesitancy and lack of knowledge around eligibility – with new hesitancy taking up flu (and other vaccinations) due to the widespread coverage of CoVID vaccine hesitancy Concern in children and young people given existing low levels of childhood immunisation uptake (worse in specific cohorts). This increases the risk of any outbreak but specific concern this winter is the potential for polio and measles.	**Autumn/Winter flu and Covid programme** -Continued progression of the C&H Strategic action plan for vaccination & immunisation focusing on 5 strategic priorities: Reducing health inequalities, community engagement, data enhancement, optimised service delivery & training and guidance for system partners -Strives to achieve uptake targets set by national (targets are a challenge for all parts of the country but particularly C&H) -Enhanced service for NE Hackney with a bespoke offer that aligns with the Jewish calendar. Continue to have orthodox Jewish specific communication resources. -Expectation is coadministration where possible -Delivered via practices, PCNs, outreach, community pharmacy and hospitals -Collaboration with Covid outreach providers at Richmond Road Surgery to reach high risk and hard to reach groups -community pharmacies will be offering both Covid and flu. -Full childhood immunisation plan in place across all partners – the national RSV vaccination programme is new this year. Vaccination UK are commissioned to provide the school based immunisation offer and there is close working between our providers.
	Winter vaccinations communications National winter vaccinations campaign assets released Rollout of winter comms campaign working with LA and community partners to promote the winter vaccines Covid, Flu & RSV available to eligible cohorts vaccination data to inform ongoing engagement work and ensure we continue to target the right groups Local comms and engagement planning will include combination of: Direct, targeted communications to reach audiences identified with specific needs/low uptake, where

	evidence shows they are more likely to benefit Face to face engagement within the communities with the lowest levels of vaccination Work with Hackney Education, schools and early years providers to promote vaccine uptake messages Care providers, MH, LD and homeless.
	Winter communications are being developed by NEL in line with national messaging but tailored to local need This campaign is being run at a NEL-level and a digital toolkit has been released which includes the campaign website, assets, and video Messaging is centred around the fact A&E departments and 999 responders experience very high demand in winter and are not always required – patients should know which services to visit for their needs. Resources for schools and early year settings Winter planning comms and resources developed by public health and shared with schools and early year settings covering immunisations, IPC support, national policy/guidance summaries **Winter wellness guide** - with holistic information on staying well including vaccinations, health services, cost of living support, information on ARRS roles and health champions to educate people on those new support roles etc…

Appendix B

Discharge Fund – City of London
The local authority allocation (£75,627) and the ICB allocation (£8,950) will be used to top-up the Discharge and Prevention Scheme.

Discharge Fund - Hackney

Scheme No.	Scheme Name	Allocation Source	Expenditure (£)
1.	Lowrie House - 6 step down beds for Homeless people	LA	£210,000
2.	Lukka Homes 3 nursing home step down beds	LA	£160,000
3.	Southwold Hospital Discharge - 16 interim beds	LA	£270,000
4.	Goodmays Flats	LA	£65,000
5.	Outwood Hospital Discharge interim beds	LA	£130,000
6.	LBH HwC interim flat furnishings	LA	£10,000
7.	LBH HwC interim flat utilities	LA	£20,000
8.	External care and support provider (24/7) within Southwold accommodation	ICB	£163,000
9.	Care packages for 4 weeks post discharge (residential)	ICB	£854,000
10.	Care packages for 4 weeks post discharge (community based)	LA	£1,447,575
11.	Hygiene Services for deep cleans	LA	£100,000
12.	ELFT Discharge Team Posts	ICB	£263,000
13.	Integrated Community Equipment Service (top up costs)	LA - £290K ICB- £39,859	£329,859
14.	LBH Move on Team	LA	£539,000
15.	LBH Brokerage capacity	LA	£285,000
16.	E-Brokerage Procurement Solution Adult Social Care	LA	£30,000
17.	Discharge personal health budget	ICB	£30,000
18.	Administration	LA	£23,000

19.	Age UK East London - Take Home and Settle Service	ICB	£28,000
20.	Integrated Discharge Service (IDS) 2 generic social worker posts & 1 MH SW post	LA	£201,000
21.	Care Transfer Hub	ICB	£334,275
22.	Pathway Team (nurse and OT)	ICB	£136,256
23.	Pathway Homeless Team GP (ELFT)	ICB	£99,910
24.	Pathway Charity Support Team	ICB	£20,700
25.	Providence row - Routes to Roots Housing Navigators	LA	£106,834
26.	NEL Care Market Project	ICB	£136,663
	Total Discharge Allocation		**£5,933,073**

Physical Capacity: Place Schemes

Name of Scheme	Scheme Detail	Lead Provider (Can be ICB)	Total Scheme Value
Mental Health Step-down beds	Five Step-down beds which will provide short-term accommodation for patients at the C&H Centre for Mental Health that are determined clinically ready for discharge but are not able to return home. ELFT sub-contract with Look Ahead to provide the accommodation.	East London Foundation Trust	£290,000.00
Proactive Care Home Visiting	Proactive Care Home Visiting (PCHV) service identifies patients at risk of hospital admission who would benefit from proactive home visiting from a GP, and provide person centred co-ordinated care, in the patient's home, resulting in effective admissions. The service is set up to support housebound patients with moderate to severe frailty. The service is over and above core GMS contract, providing proactive rather than reactive input and personalised support to patients most at risk of unplanned admission, readmission, and A&E attendances.	GP Confederation	£214,812.72
Enhanced Support Pathway for Children & Young People with Learning Disabilities/Autism	This proposal outlines an enhanced support pathway within the CAMHS Disability service to proactively address escalating mental health concerns and challenging behaviours in children and young people with learning disabilities and/or autism. The model aims to prevent crises, reduce the need for Tier 4 or emergency services, and minimise hospital stays by providing intensive, community-based support tailored to the unique needs of this vulnerable population.	Homerton	£88,938.98
Making Room Decluttering Service	The purpose of this scheme is to test the integration of the specialist decluttering service 'Making Room' provided by MRS Independent Living into hospital discharge processes so that patients with moderate to severe levels of clutter can be offered decluttering support to ensure a safe and sanitary home environment prior to discharge.	MRS Independent Living	£26,667.67

	Making Room will liaise with existing discharge services to adapt their existing therapeutic decluttering service model (delivered over an average of 10 weekly sessions) into a discharge-focused model that focuses on maintaining a safe, habitable and sanitary living environment for rehabilitation at home, and supporting patients for up to 6 weeks' post-discharge to address their hoarding behaviour with a view to achieving longer-term behaviour change and risk reduction.		
Winter Communications	• Design costs for Winter Wellness Guides localised to place • Print and distribution of 3,000-5,000 copies of Winter Wellness guides to key public spaces and GP practices • Translations of Winter Wellness Guides into top 3-5 languages • Any money left over we will use to do digital advertising to promote the guides and winter website.	NEL ICB	£5,000.00
Social Work Capacity	3 social workers will be employed to increase capacity within adult social care to engage more quickly in discharge planning. Two will support the Homerton Hospital; one on the Elderly Care Unit and one on the Stroke Unit as the complexity of the patients on both wards require more detailed assessment and planning. The third social worker will be dedicated to support out of borough patients, predominantly at the Royal London which has a large volume of Hackney residents.	London Borough of Hackney	£60,078.75
		Total slightly under place allocation	£685,498.12

Physical Capacity – Homerton Hospital

Scheme Name	Scheme Description	Cost
HH Defoe	Defoe open for 6 months	£966,000
HH CSM	B8A 3WTE, 2-11pm, 7 days, October to March	£119,940
HH HAMU in-reach	B6x1WTE, 6-10 months	£25,788
HH Domestic Cleans	Additional domestic dedicated to terminal cleans 4-8pm, 15 hours per day, October to March	£71,000
HH Flow Assistant	Dedicated flow assistant to ED and ACU, B2 24/7	£90,187
HH ED flow coordinator	Administrative patient flow coordinator in UEC pathway B4 3WTE, 8 hours, 7 days, October to March	£56,334
HH Ecolab	Enhanced capacity for quick lab results	£10,015
HH Transport	ERS Additional ambulance 7 days per week	£171,451
HH Discharge Support	Patient flow co-ordinator - B7 - 2WTE	£67,630
HH UEC	B3 HCA x2WTE	£34,568
HH UEC	6-month 1.00WTE Band 8A Emergency Advanced Nursing Practitioner (ANP).	£36,992
HH Starlight ward	B5 Transfer nurse	£22,936
HH ITU	B6 ITU Transfer Nurse	£28,097
CUF Uplift confirmed since schemes planned so reconfirming costs		**£1,700,938**

	● engage local communities to build trust and cultivate a co-productive approach; ● enhance data systems to drive quality improvement; ● optimise service delivery through evidence-based practice, system-feedback, and resource planning; and ● provide guidance, training and development across the system as part of the approach to Making Every Contact Count. The full Strategic Action Plan is enclosed.
Action / recommendation	The Board/Committee is asked to: **approve** the action plan.
Previous reporting	The plan is currently undergoing ratification, and has been presented to, endorsed, and approved by the following operational and strategic groups: ● Public Health Senior Management Team ● City and Hackney Children and Young People Immunisations Group ● City and Hackney Vaccination and Immunisation Steering Group ● City and Hackney Health Protection Forum ● City and Hackney Place-Based Partnership Delivery Group ● City and Hackney Place-Based Partnership Executive Group (Previously the Neighbourhood Health and Care Board) The Strategic Action Plan has also been reviewed and endorsed by Dr Anita Bell, Consultant in Health Protection, UK Health Security Agency (UKHSA), North London Health Protection Team. Following feedback, the plan has been updated to reflect the following recommendations: 1. **Outbreak related vaccine response arrangements:** A specific action has been added to the action plan under Strategic Priority 3, Outcome 3.1, to enhance coordination, including data-driven activities during outbreak scenarios. 2. **An evaluation framework:** Based on the feedback, the action plan now includes ongoing process evaluation as a continuous component, rather than being limited to the scheduled mid-term review in 2025. This will allow for real-time insights and adjustments. 3. **An outcome focused vision:** The vision has been updated to emphasise the importance of vaccination as one of the most effective interventions for safeguarding health, prioritising health inequalities in coverage and outlining the steps we will take to address the plan.

	4. **Coordination and collaboration with various agencies:** Feedback highlighted opportunities for working with cross-sector partners in the delivery or engagement of vaccination in community spaces. These considerations are now reflected in Strategic Priority 4, Outcome 4.4. 5. **Preparation for devolved commissioning:** Strategic Priority 4, Outcome 4.5 has been added to include specific commitments for preparing for and transitioning to immunisation commissioning responsibilities being devolved to Integrated Care Boards (ICBs) expected in 2026.
Next steps/ onward reporting	This is the final stage of the ratification process. If approved, the plan will be published as final. For further oversight and support with delivery against this action plan, it will be taken to the London Borough of Hackney Health and Wellbeing Board and City of London Health and Wellbeing Board in 2025.
Conflicts of interest	There are no conflicts of interest to manage in relation to the decision requested/issues raised.
Strategic fit	The plan aligns with the following ICS aims: ● 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 City and Hackney Immunisation Strategic Action Plan is underpinned by a multi-pronged, evidence-based approach to improving immunisation uptake and will deliver outcomes that impact on: ● **local people:** by addressing barriers related to convenience (access), confidence and complacency, the plan aims to improve vaccine coverage, thereby reducing the risk and transmission of VPDs. Improved coverage will also confer additional public health benefits, such as reduced morbidity and mortality from cancers related to specific vaccines, like HPV (human papillomavirus), as well as reduced prevalence from certain sexually transmitted infections, such as hepatitis B. ● **health inequalities**: the plan focuses on increasing vaccine uptake among underserved and inclusion health groups by addressing barriers through community engagement and co-production, optimised service delivery, and vaccine advocacy as part of making every contact count. ● **sustainability**: by promoting health equity and reducing inequalities,the plan will ensure that communities have access to vaccines and are safeguarded against VPD-related outcomes, contributing to long-term public health sustainability.
Has an Equalities Impact Assessment been carried out?	An Equalities Impact Assessment (EIA) has not been carried out because the plan's core vision is to reduce health inequalities and remove barriers to vaccination uptake among underserved and disadvantaged groups.

	The plan has been developed through a comprehensive needs analysis, which included a data review of the immunisation profile and consultation with various stakeholders, which identified existing inequalities in vaccine uptake and access, and their underlying drivers. The plan itself aims to address inequalities in vaccine uptake, by addressing complacency, confidence and convenience barriers. Since the plan has been informed by a needs assessment and equality-focused lens, a separate EIA has not been deemed necessary.
Impact on finance, performance and quality	**Financial impact:** ● The implementation of this Strategic Action Plan is reliant on multiple funding streams including health protection expertise and resource from City and Hackney Public Health Team; NHS England funding to primary care and school age immunisation providers; and non-recurrent funding from NHS NEL ICB for the coordination of immunisation activities, campaigns, communications and community engagement work. Non-recurrent funding is also sometimes made available from NHS England, typically to support local responses to specific VPD risks/threats. Often, as a consequence, deliverables tied to this funding therefore tend to be reactive. ● A key risk relating to insufficient and non-recurrent funding is outlined in the section below. In summary, sustainable and sufficient recurrent funding would support more effective and proactive immunisation efforts. ● While commissioning responsibilities are set to transfer to ICBs in 2026, there are still many unknowns regarding how devolved commissioning will operate at regional and local level, including specifics around budget allocations, resource requirements, and the structure needed to support local vaccination models. As a result, this plan remains a live and iterative action plan that will be continuously updated to reflect potential changes in the commissioning landscape, and to ensure that goals and deliverables are aligned with the latest funding and operational frameworks. **Impact on performance and quality:** ● The plan aims to optimise service delivery and quality through the implementation of best practices and use of alternative vaccination sites. ● The plan has been developed through system-wide collaboration (including providers and other relevant parties that engage with eligible cohorts), supporting a comprehensive approach to vaccine planning and delivery. This approach will ensure that the needs of

	the diverse population are effectively met, while improving overall accessibility and service quality.
Risks	Key risks to the plan's implementation and evaluation: ● **Data quality and accessibility:** most immunisation data is aggregated to the City and Hackney combined level. Therefore, we are unable to analyse immunisation data by bespoke geographies, population groups and trends. This is a longstanding issue which, despite multiple attempts to escalate and/or co-develop a solution, has not yet been resolved. This issue has been escalated to the NEL data team and NHSE London commissioners to try and identify a solution. Although there were discussions within NEL to develop an immunisation data dashboard, as is in place in other Integrated Care Systems, progress towards this appears to have stalled. Attempts to access data directly have also been unsuccessful. This situation results in efforts being less data-driven, impacts our ability to identify and address inequalities in immunisation uptake, impedes our understanding immunisation uptake within the City of London, and prevents us from monitoring and evaluating local initiatives, including our ability to monitor and evaluate the impact of this Strategic Action Plan. ● **Insufficient and non-recurrent funds:** Funding to support the implementation of this action plan is insufficient. In particular this relates to budgets for targeted and co-produced communications campaigns, engagement and potential partnership work with community and voluntary sector organisations, and optimising service delivery (including call/recall and establishing clinics in community settings to increase access). Additional funding received tends to be non-recurrent and associated with a specific campaign and therefore does not support a strategic approach. Programme management support for delivery of many of the items within the plan is unclear past March 2025 when funding for the post runs out. ● **Lack of clarity over devolved commissioning arrangements:** intentions to 'delegate responsibility for commissioning NHS vaccination services to ICBs' by April 2025, as outlined in the NHS vaccination strategy, have been delayed at least until April 2026. No details surrounding this delegation have been provided, including relating to funding, which hinders local abilities to plan and prepare for this transition.

City and Hackney Immunisations Strategic Action Plan 2024-2027

Developed in collaboration with City and Hackney Public Health Team and the North East London Health & Care Partnership

Published: September 2024

NHS North East London

CITY OF LONDON

Hackney

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Executive Summary

After clean water, immunisations are the most effective public health intervention in the world for saving lives and promoting good health. The UK offers a comprehensive vaccination programme across the life-course, protecting millions of people each year from vaccine-preventable disease (VPDs) and outbreaks, severe illness and death.

Despite the above, coverage for routine immunisation programmes nationally, regionally and locally has been in decline in recent years accompanied by large inequalities in uptake between population groups. Coverage for several programmes falls below the World Health Organisation (WHO) targets, resulting in localised outbreaks of VPDs such as measles and pertussis in recent years. The unique population demographic composition in City and Hackney, coupled with widening inequalities in vaccination coverage, underscores the need for a comprehensive immunisation strategic action plan.

The need to improve vaccination coverage has been widely acknowledged in global and national policies, including recent publications like the NHS Vaccination Strategy (2023). As such, this plan aligns with the national direction of travel and equally reflects the priorities set forth in City and Hackney Joint Strategic Needs Assessments.

Considering the above, our future approach to vaccination will be guided by community-, data- and system-led insights to address barriers to vaccination, and support delivery of immunisations to all eligible residents. The five strategic priorities, to be delivered over a three-year span between 2024-27, are set as follows:

1) reduce inequalities in immunisation coverage among inclusion and high-risk groups;
2) engage local communities to build trust and cultivate a co-productive approach;
3) enhance data systems to drive quality improvement;
4) optimise service delivery through evidence-based practice, system-feedback, and resource planning; and
5) provide guidance, training and development across the system as part of the approach to Making Every Contact Count (MECC).

In developing the strategy, we have sought the views of a wide range of stakeholders including commissioners, providers and organisations supporting vaccination programme delivery. An emphasis has also been placed on engaging stakeholders with a community focus, as well as those who directly interface with eligible residents. This approach supports our ambitions to raise awareness of vaccination as part of MECC, and building trust within the community. These partnerships will play an important role in the successful delivery of this plan.

Key stakeholders will maintain oversight of the delivery and implementation of this plan. The plan will be delivered over a three-year period (2024-27) with a mid-term review scheduled for 2025. As a living document, the plan and its deliverables, will undergo continuous process evaluation, which will inform future activity and priorities.

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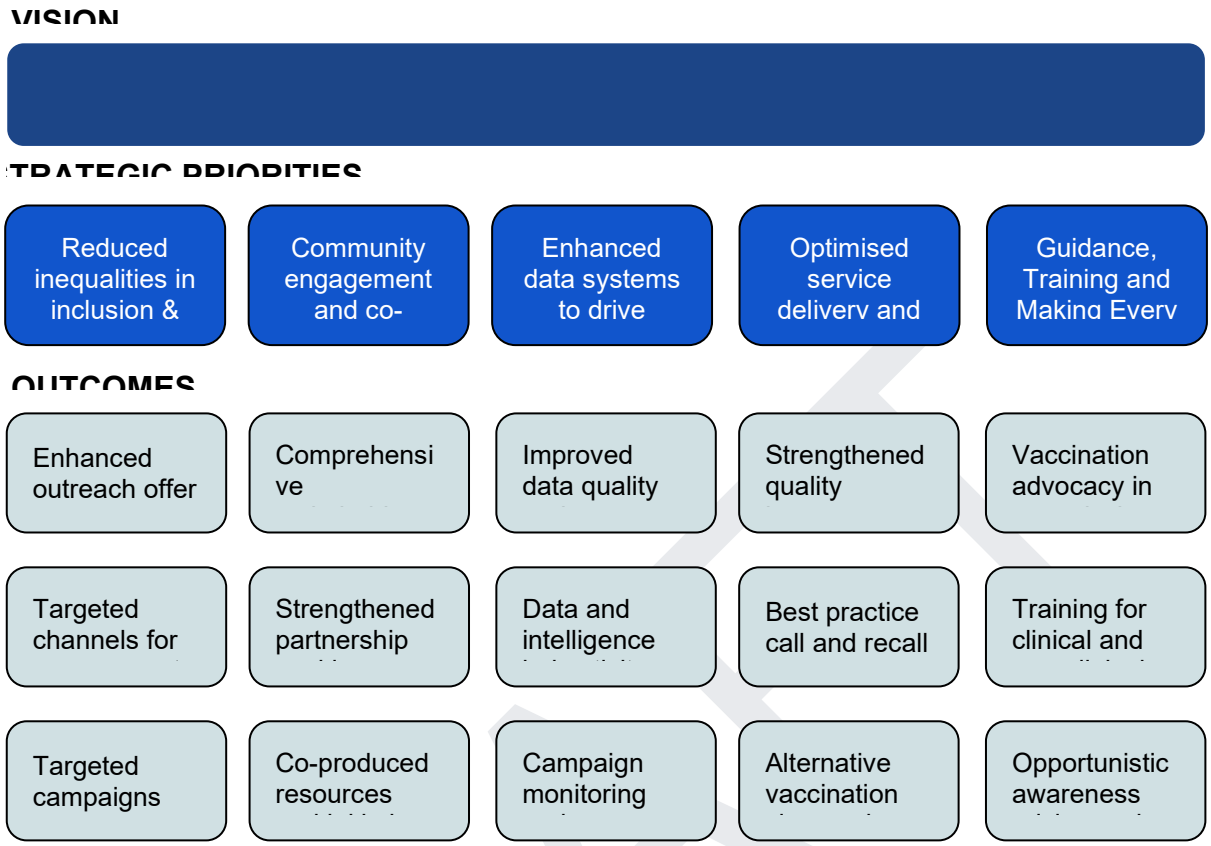
City and Hackney Immunisations Strategic Plan on a Page



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1. Introduction aims and objectives

1.1 Background

After clean water, immunisation programmes are the most effective means of safeguarding individuals and communities against vaccine-preventable diseases (VPDs). (1) A comprehensive routine and selective vaccine programme is in place in England, which targets ages across the lifecourse, and specific groups at greater risk of exposure or susceptibility to VPDs (Appendix 1). (2)

Globally, vaccination is estimated to prevent 3.5-5 million deaths per year. Vaccination programmes have also contributed to the marked reduction in the incidence of vaccine-preventable cancers and morbidity attributed to infectious diseases like polio (Fig. 1). (3) These achievements have been accompanied by additional public health benefits, such as a reduced demand for antibiotics (thus reducing antimicrobial resistance), as well as savings to the health and social care system over time.

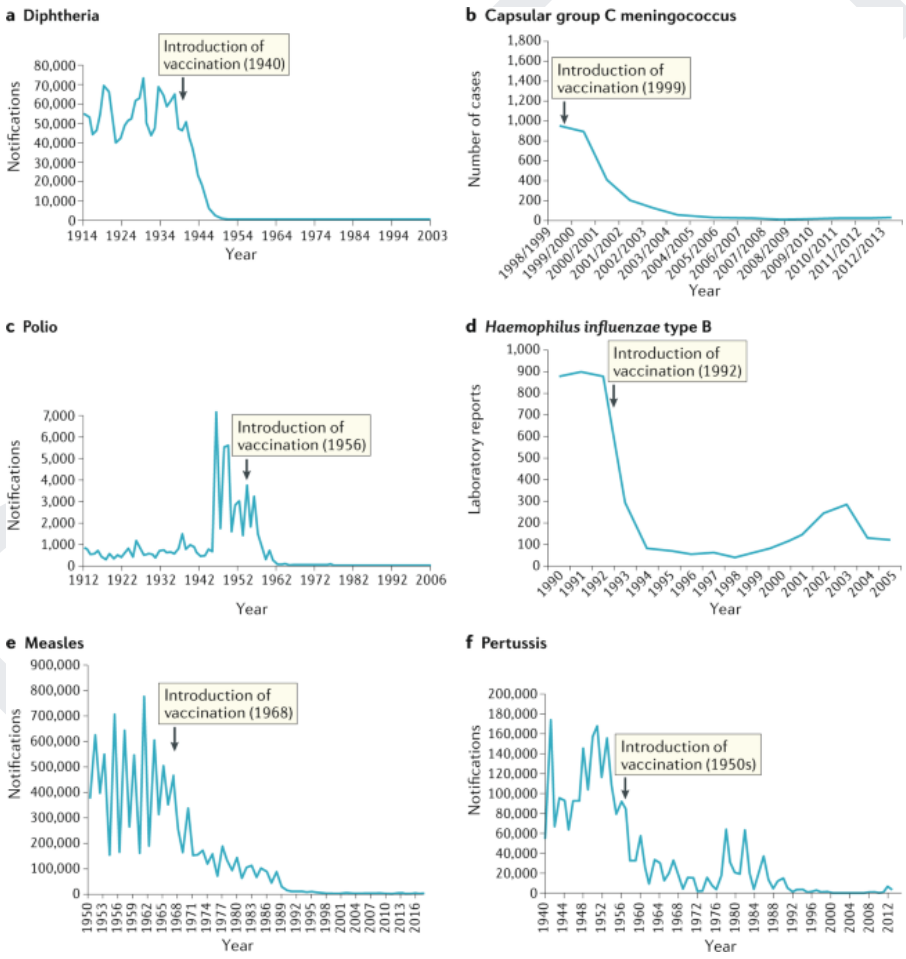

Figure 1. The impact of vaccination on selected diseases in the UK overtime.

However, over the last decade, there has been a concerning downward trend in vaccine coverage nationwide. (4) As a consequence, the UK has failed to achieve the WHO's 95%

target for herd immunity[1] resulting in the loss of its elimination status for diseases like measles. This decline leaves populations, particularly vulnerable groups, exposed to the risk of VPD outbreaks, which could have severe and disproportionate consequences. With increasing pressures on the health and care system as well as financial pressures on public health investment, it is essential to ensure that vaccination programmes in City and Hackney reach their full potential.

1.2 Why we need a City and Hackney Immunisation Strategic Action Plan

Across England, immunisation coverage rates for routine immunisation programmes have continued to decline since 2013, exacerbated by the COVID-19 pandemic, and growing erosion of trust around vaccinations.

In London, childhood immunisation coverage rates have declined at a steeper rate compared to the national trend. (4) The rates of decline observed in City and Hackney are even greater (Appendix 2), thereby raising concerns regarding the risk to public health from VPDs.

As a point of illustration, recent modelling by the UKHSA has estimated a threat of a measles epidemic of between 40,000-160,000 cases in London, driven by sup-optimal measles, mumps and rubella vaccine (MMR vaccine) rates across the capital. This risk has already materialised in London boroughs, including Hackney, with small measles outbreaks as well as pockets of pertussis reported since 2018 (Fig. 2).

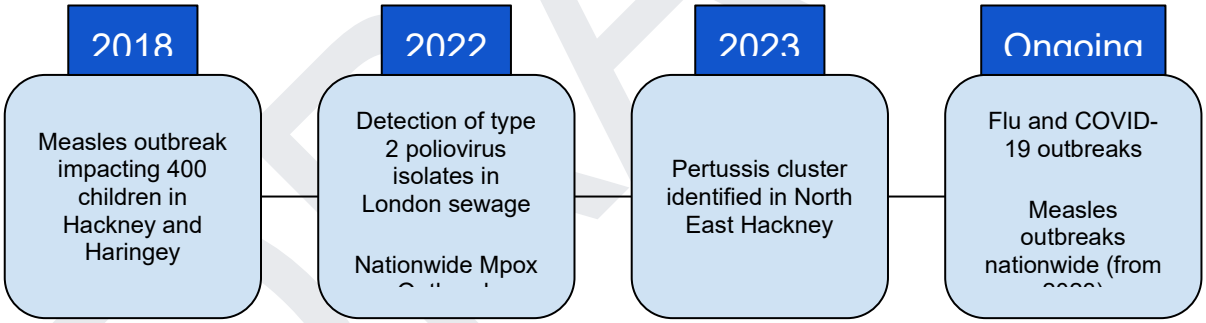

Figure 2. Timeline of infectious disease outbreaks and events in Hackney, London and England between 2018 and 2024.

Inequalities in immunisation uptake are influenced by multiple factors. Certain population groups, such as residents who live in more deprived and urban areas, and those belonging to specific ethnic minority backgrounds, have consistently lower immunisation uptake rates than others, both nationwide and locally. Contributing factors include cultural and language barriers, misinformation and vaccine hesitancy, institutional mistrust and accessibility challenges for some population groups.

City and Hackney are dynamic and diverse inner London areas with a rich cultural and ethnic mix. Hackney ranks amongst the top 10 most deprived authorities in England, accompanied by a child poverty rate of 43%. It is estimated that 64% of Hackney and 62% of City of London

[1] Herd immunity is the indirect protection from an infectious disease that happens when a population is immune either through vaccination or immunity developed through infection .

residents come from a non-white British ethnic background. (5) Therefore, achieving optimal vaccine uptake and reducing inequalities in vaccine coverage is a key local challenge.

The burden of VPDs are likely to disproportionately impact disadvantaged and vulnerable communities, thereby exacerbating existing health inequalities. As such, a comprehensive and targeted approach to immunisation is required to address the unique needs of City and Hackney.

1.3 How we developed this strategic action plan

A comprehensive approach was undertaken in the development of this strategic action plan. Specifically, the plan is underpinned by (Fig. 3):

- an Immunisations Data Review (Appendix 2) to provide a profile on immunisation coverage in City and Hackney;
- a literature review of interventions shown to increase vaccine uptake (Appendix 3) to inform evidence-base recommendations for action;
- visits to general practices across City and Hackney, to gather qualitative insights and local intelligence around the drivers of immunisation uptake across the footprint;
- alignment with national, regional and local policy context, vision and priorities;
- stakeholder engagement in shaping the actions outlined in this plan.

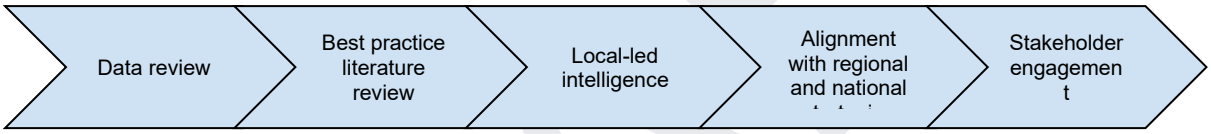

Figure 3. Strategic Action Plan Development Approach

1.4 Our vision and strategic priorities

Our vision is to safeguard all communities from vaccine-preventable diseases by increasing and addressing inequalities in immunisation coverage through action of community-, data- and system-led insights.

Taking into consideration our overarching vision, our five strategic priorities are:

- **reduce inequalities** in immunisation coverage among inclusion and high-risk groups;
- engage **local communities** to build trust and cultivate a **co-productive approach**;
- enhance **data systems** to drive **quality improvement**;
- **optimise service delivery** through **evidence-based practice, system-feedback,** and **resource planning**; and
- provide **guidance, training and development** across the system as part of the approach to **Making Every Contact Count**.

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2. Policy Context

2.1 National Policy

The City and Hackney Immunisation Strategic Action plan is underpinned by national policy and strategy. Notably, our local plan aligns with priorities set out in the:

- NHS Long-Term Plan (2019) which prioritises improvements in childhood immunisation to meet minimum standards; (6)
- Public Health England Immunisation Inequalities Strategy (2019) which aims to address inequalities and ensure equity in the delivery of the national immunisation programme; (7)
- NHS Vaccination Strategy (2023) which outlines clear priorities in delivering vaccinations through targeted outreach and a joined up prevention offer; (8)
- National Framework for Action on Inclusion Health which provides a framework for optimising health services to effectively meet the needs of those who may be socially excluded and or experience multiple interacting risk factors for poor health. (9)

2.2 Regional Policy

City and Hackney fall within the North East London (NEL) footprint. Formally established in July 2023, the NEL Health and Care Partnership operates as a statutory committee, bringing together a diverse range of system partners to plan and deliver joined up health and care services. (11) Notably, the NEL Integrated Care Strategy (2023) recognises vaccination as a key strategic priority in improving health outcomes, particularly among ethnic minority groups. (11)

This strategic action plan also reflects the principles detailed by the London Immunisation Board Principles for London Vaccination Programmes in 2023, (12) and the internal publication of the NEL Vaccination and Immunisation Strategy (2024-27) (which City and Hackney colleagues helped shape) and it's underpinning pillars which prioritise:

- reducing inequalities and improving uptake in underserved and inclusion health groups;
- community engagement and promotion;
- data sharing and quality improvement;
- optimised service delivery and resource planning; and
- guidance, training and development.

The NHS NHS vaccination strategy outlined that delegation of vaccination commissioning responsibility to ICBs, is intended to be completed by April 2025. Therefore this strategic action plan supports the planning and preparation for these anticipated changes.

2.3 Local Policy

At local level, immunisation-related priorities have been integrated into local workstreams, needs assessments and strategic documents for City and Hackney:

- Improving childhood immunisation uptake is a shared priority within the Integrated Children, Young People and Maternity and Families (CYPMF) Integrated Workstream. In addition, the health needs assessment for the population aged 0 to 19 in City and

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Hackney (2022) outlines a commitment to promote and protect the health and wellbeing of children through vaccination awareness raising and engagement. (13)

- The plan aligns with the City and Hackney Sexual and Reproductive Health Strategy (2024-29)[2] and priorities set out in the City and Hackney Cancer Joint Strategic Needs Assessment (2024)[3] which aim to reduce the local burden of vaccine-preventable sexually transmitted infections and cancer, by ensuring equitable access and uptake of routine and targeted vaccine programmes.

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[2] *Internal document; available on request*
[3] *Internal document; available on request*

3. What the data, intelligence and evidence tells us

3.1 Immunisation coverage in Hackney

A comprehensive routine and selective vaccine programme is in place in England. Sub-optimal vaccination coverage across the programmes poses an ongoing risk of VPD incidence and outbreaks. (2)

Childhood immunisation programme: Hackney has observed a consistent pattern of decreasing childhood immunisation coverage since 2013. This decline appears to have been exacerbated during the COVID-19 pandemic. Coverage in Hackney is among the lowest in the country. For key performance indicators, the coverage for two doses of MMR (measured at 5 years) stands at 56.3%, significantly below the national average of 84.5%. Similarly, coverage for the combined 6-in-1 vaccine (primary series) (measured at 1 year) is 67.8%, well below the national average of 91.8%, and below the WHO target of 95% for herd immunity (Appendix 2).

Geographical coverage has also highlighted inequalities, with lower vaccine coverage concentrated in the north of the borough, which also coincides with areas of higher deprivation and diverse ethnic representation.

Seasonal immunisation programmes: vaccine coverage for the flu vaccine among over 65s has remained relatively stable with minor fluctuations, averaging at 61.4% in 2022-23, but below the national average of 79.9%. COVID-19 vaccine coverage shows variations by ethnicity and deprivation, with improved coverage rates generally observed in areas of lower deprivation.

Immunisations for older adults: the vaccine coverage for the pneumococcal (PPV) vaccine has fluctuated slightly over the past decade, currently measuring at 62.2%, which is below the national average of 70.6%. Shingles coverage trend data is limited, but has remained stable since 2019, and measures at 27.4%, below the national average of 44.0%.

Vaccines that prevent sexually transmitted infections: vaccines that prevent sexually transmitted infections include the HPV vaccine (which is now offered to both girls and boys), alongside hepatitis A and B vaccines. The 2022 nationwide mpox outbreak also prompted the UK to offer smallpox vaccinations to eligible patients through sexual health services.

Overall, the HPV vaccine coverage for females (one dose) has shown a downtrend, declining from a peak of 97.1% in 2015, to 61.7% in 2021-22. Coverage for males (one dose) is 55%, lower than the national average of 62.4%, and lower than the uptake observed in females.

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3.2 Qualitative insights: what can be improved

Qualitative insights into local immunisation programmes were obtained through engagement and facilitation of questionnaires across GP practices in City & Hackney. The insights have been grouped, utilising the 3C model which defines the three main factors influencing vaccine uptake (confidence, complacency and convenience) (Table 1).

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Table 1. Qualitative Insights into Immunisation Programmes in City & Hackney	
Challenge	Details
Confidence barriers (for example., trust in vaccine safety and efficacy, adequacy of the system or policy makers)	
Concerns/fears over vaccine side effects and long term impact	● There are vaccine specific community concerns such as those relating to the perceived link between the MMR vaccine and autism. ● There are fears over immune system overloading and/or immune systems being too immature for vaccines at younger ages.
Trust in information received	● Increased suspicion due to COVID vaccination policy reversals now affecting perceptions of other vaccines. ● There is doubt regarding the effectiveness and relevance of specific vaccines e.g. "*I had my COVID vaccine and still got COVID*".
Cultural barriers	● For example, some communities have raised concerns over porcine ingredients in specific vaccines.
Complacency barriers (for example., low perceived disease risk, low in general knowledge and awareness)	
Risk perception	● The perceived risk of VPDs often leads to complacency, with families delaying vaccination until there are local cases or until their child becomes unwell before taking action.
Immunising, but not to schedule	● Some residents are not against vaccination but want to wait until their child is older before receiving their immunisations. ● In 2022/23 68.1% had one dose of MMR at two years of age, compared with 81.2% with one dose at five years of age.
Large unregistered population	● People who are not registered with a GP are at risk of not being invited to routine vaccination.
Convenience barriers (for example., vaccine availability, accessibility and affordability, resulting in structural and or psychological barriers)	
Accessibility of appointments	● Families with more children often have difficulty accessing vaccinations as they struggle (logistically) in taking multiple young children to health services. Due to this, a child's birth order is inversely related to their vaccination status. ● Some appointments feel rushed both from a GP and parent perspective.

High did not attend (DNA) rates	• The number of patients booked for appointments exceeds those actually attending, impacting effective call/recall.
Receptionist capacity	• Some practices have a high turnover of administration staff, resulting in knowledge loss and challenges in sustaining implementation of best-practice approaches e.g. towards call/recall and patient engagement activity. • There is a lack of protected administration time for call-recall activity. • Some non-clinical staff are too busy to opportunistically invite children for vaccinations based on EMIS notifications.
Inconsistent call/recall methods	• Varying process and systems used across GP practises some of which are not best practice recommended methods.
High population movement	• New arrivals to the UK may be unfamiliar with the health system or national immunisations schedule which is posing challenges in adhering to the routine schedule. • Immunisations administered abroad pose difficulties in translating immunisation codes and determining the required vaccinations. • Patients who leave but don't change GPs 'ghost patients' impact call/recall activity and uptake monitoring. • Frequent travel within City and Hackney, and to countries where infections are endemic, is increasing the risk of importation and community spread.
Data recording, data accuracy and data flow onto reporting systems	• There is a delay in accessing timely immunisation records such as from vaccinations administered through alternate providers, resulting in inaccurate call/recall lists. • Records maintained by the Child Health Information Service are incomplete. This poses a challenge in ascertaining the vaccination status of school-age children by school.
Language barriers	• There are a large number of residents for whom English is not their first language. This presents challenges in ensuring that communications around immunisations have been interpreted correctly.

3.3 Interventions shown to increase vaccination uptake

The literature, summarised in Appendix 3, summarises the evidence-base interventions recommended to drive improvements in vaccination uptake, as well as reduce inequalities at a local level. The findings of the review, presented in Table 2, aim to address the specific barriers summarised in earlier sections, as well as incorporating general best practice.

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Table 2. Summary of evidence-based recommendations for improving vaccine uptake	
Confidence	● Tailored communication efforts available in multi-media formats and languages ● Tackling misinformation ● Training to support confident conversations through clinical and non-clinical workforce, as part of making every contact count
Complacency	● Effective call and recall systems ● Engagement with hesitant individuals and communities ● Clarification of the vaccination schedule ● Educational and myth-busting initiatives
Convenience	● Opportunistic vaccination offer, including integrated health offers ● Vaccinations in community settings ● Flexible appointments ● Extended clinic hours

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4. Our vision, strategic priorities and action plan

4.1 Where we want to get to (the vision and objectives)

Our vision is to safeguard all communities from vaccine-preventable diseases by increasing and addressing inequalities in immunisation coverage through action of community-, data- and system-led insights.

Taking into consideration our overarching vision, our five strategic priorities, to be delivered over a three-year span between 2024-27, are set as follows:

- **reduce inequalities** in immunisation coverage among inclusion and high-risk groups;
- engage **local communities** to build trust and cultivate a **co-productive approach**;
- enhance **data systems** to drive **quality improvement**;
- **optimise service delivery** through **evidence-based practice, system-feedback, and resource planning;** and
- provide **guidance, training and development** across the system as part of the approach to **Making Every Contact Count**.

4.2 Partnerships

The governance of immunisation programmes involves a complex network of agencies, organisations and system-partners. NHS England (NHSE) commissions routine immunisation programme delivery while agencies such as the Joint Committee on Vaccination and Immunisation provide evidence-based guidance for clinical policy-making. Immunisation services are delivered through various providers from general practices and community pharmacies, to school age immunisation providers and sexual and reproductive health services. The UK Health Security Agency prevents, prepares for and responds to infectious diseases, at both individual and population level, which includes vaccine delivery to prevent and control outbreaks. Finally, local authorities work with place-based system partners to ensure that immunisation programmes are delivered in a safe, effective, accessible and equitable manner.

Partners across the local system and North East London Integrated Care System (ICS) have an important role in increasing immunisation coverage and reducing inequalities in vaccine uptake (Fig. 4). Recognising this, our plan aims to broaden collaborations with the full range of partners, particularly those that interface with eligible cohorts across the course.

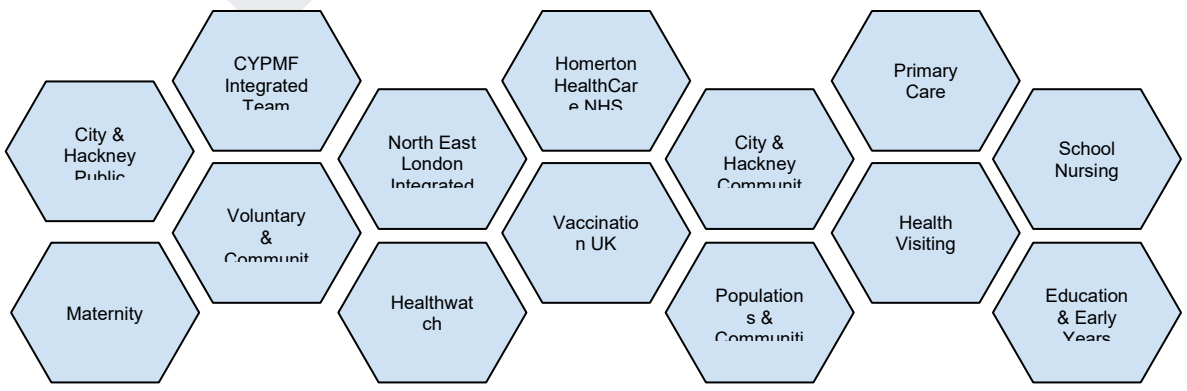

Figure 4. System partners involved in the coordination, delivery and promotion of immunisation programmes across City and Hackney.

4.2 Governance and accountability

The implementation of this strategic action plan will mainly be overseen by the City and Hackney Children and Young People Immunisations Group and the City and Hackney Vaccination and Immunisation Steering Group. Oversight of the delivery of the strategic action plan, as well as strategic input and guidance, will take place at the City and Hackney Health Protection Forum. Overall accountability for the successful delivery of the action plan sits with the City and Hackney Health and Care board, via the City and Hackney Place-Based Partnership Delivery Group and the City and Hackney Place-Based Partnership Executive Group (Fig. 5).

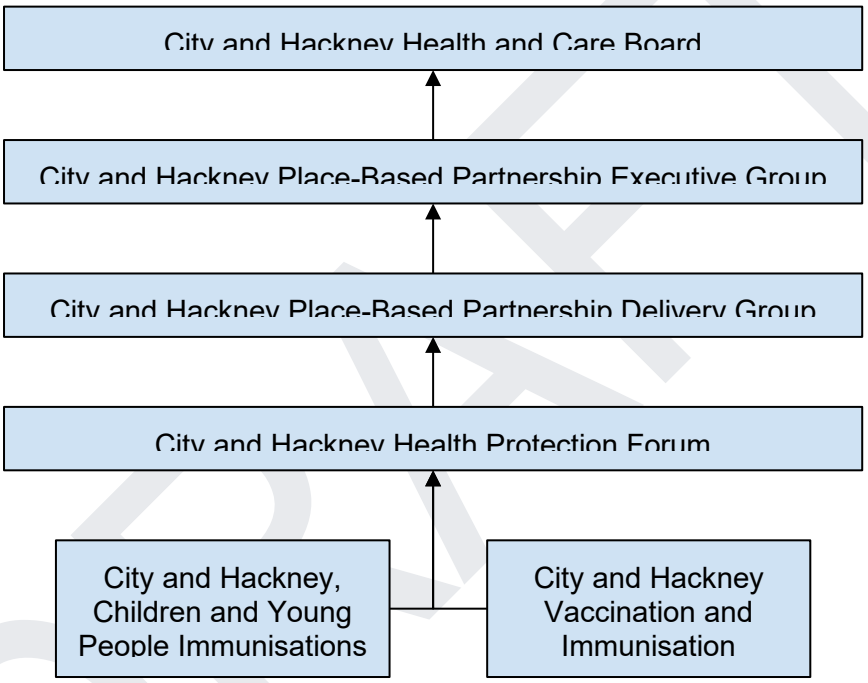

Figure 5. City and Hackney Immunisation Strategic Action Plan: Governance and Accountability Framework

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5. Strategic priorities explained

This section delves deeper into each of the strategic priorities outlined in the action plan. For every strategic pillar, we have provided a rationale for its selection, a summary of existing work contributing to this area of activity, and an overview of the strategic objective.

5.1 Strategic Objective 1: Reduce inequalities in inclusion and high-risk groups

Rationale: Inclusion health is an umbrella term used to describe people who are at risk of social exclusion and who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma (Fig. 6). (14)

People belonging to inclusion health groups may experience stigma and discrimination, and are not consistently included in electronic records such as healthcare databases. They frequently suffer from multiple ongoing health problems, and face barriers to accessing healthcare interventions and services, including immunisations.

Additionally, certain populations within City and Hackney are considered high-risk due to significant disparities in vaccination uptake. These groups, such as looked after children, are particularly vulnerable to disproportionate health outcomes due to the compounding effects of broader health determinants and inequalities. As a result, addressing the health needs of these groups is essential to tackling inequalities.

Overall, people belonging to inclusion health and high-risk groups face several challenges and are:

- at greater risk of being exposed to vaccine preventable diseases (for example, through high-risk working conditions, overcrowded living conditions and limited access to hygiene or sanitation facilities);
- more likely to have poorly managed ongoing health problems that increase their risk of serious illness;
- more likely to be affected by vaccine preventable outbreaks, due to various factors including those previously mentioned, as well increased vulnerability to incomplete immunisation status, compromised immune systems and challenges in accessing healthcare services.

Immunosuppressed & high-clinical risk populations	Asylum seekers, refugee & vulnerable migrants	Looked after children
Those with learning disabilities	Homeless populations	Homeschooled children
Those with severe mental illness	Sex workers	People in contact with the justice system
Social care worker & carers	Those with drug and alcohol dependencies	Unregistered residents

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Figure 6. List of inclusion health and high-risk groups specific to City and Hackney

What's been working well: The 2023 autumn-winter COVID campaign introduced a novel outreach approach, led by a collaboration between Richmond Road Medical Centre (local GP provider) and Public Health. The strengthened partnership helped to identify and facilitate in-and-outreach vaccination events to at-risk groups. Over 30 vaccination pop-up clinics were held in a variety of community settings, including asylum seeker hotels and community soup kitchens, alongside community celebratory events such as the Winter Fair. The collaborative approach helped to build connections with key voluntary and community sector groups as well as wider system partners.

Objectives: We need to continue to establish clear pathways of communication with partners and work collaboratively to gain a deeper understanding of the prevalence and locations of inclusion health and high risk and groups, and their service access patterns.

Our goal is to trial peer-led approaches involving individuals with lived experience (for example, people who have experienced homelessness) to work alongside health and social care professionals. This approach aims to support ways of working and deliverables (e.g. communication and engagement initiatives) that lead to improved outcomes.

Strengthened partnership working with community and voluntary sector groups (e.g Shelter) will be key to enhancing our outreach offer. Outreach offers will continue to be guided by making every contact count (MECC) principles, with vaccinations provided as part of broader health and wellbeing initiatives (i.e. integrating outreach with other community wellbeing events) to maximise reach and accessibility.

Given funding for reducing inequalities in immunisation uptake is regularly made available, and often at short notice in response to emerging VPD threats, we need to be prepared for how to best bid for an/or utilise additional funding that is made available.

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5.2 Strategic Objective 2: Engage local communities to build trust and cultivate a co-productive approach

Rationale: City and Hackney are rich in diversity, and are home to people from a wide range of ethnic and religious backgrounds. A large proportion of residents are non-English speaking, and socio-economic status varies across the borough.

Our data and intelligence reveal inequalities in immunisation coverage among various population groups, including individuals from Black or mixed backgrounds . We understand that specific communities within City and Hackney have distinct reasons for delaying or declining vaccines, which will require targeted intervention appropriate to all segments of the population.

Evidence-based recommendations from the literature, and anecdotal experience, have demonstrated the value of communities in the promotion, delivery and uptake of immunisation programmes. Whilst we have achieved significant milestones through community engagement with some groups, we acknowledge the importance of ongoing efforts to establish new partnerships across the spectrum. This targeted approach will be vital to building trust and overcoming confidence and convenience barriers, ultimately contributing to the reduction of inequalities in the long-term.

What's been working well: Our community engagement efforts have provided invaluable insights into the challenges surrounding vaccine delivery and access, as well as the cultural appropriateness and effectiveness of some communication initiatives.

In recognition of these challenges, we have implemented regular Sunday immunisation clinics (enhanced access clinics) in the North East of Hackney, in collaboration with local GP practices and partners from the Charedi Jewish communities. Additionally, vaccinations are now offered at community centres during the weekday, advertised through co-produced communication and promotion resources. As a result, over 4,000 childhood immunisations have been administered between September 2022 and May 2024.

It is critical that the enhanced access offer and community engagement activities continue in the North East of Hackney in coming years, where uptake is lowest to build on the strong foundations established.

Objectives: Our objective is to map voluntary and community sector groups and organisations that engage with populations with low vaccine uptake. This mapping exercise and establishment of community partnerships will provide a strategic opportunity to:

- expand our reach and awareness raising through co-produced and community led initiatives;
- ensure that targeted communication and engagement campaigns are impactful; and
- integrate vaccination offers into existing health and wellbeing provision, and or community infrastructure to promote long-term engagement with immunisation initiatives.

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5.3 Strategic Objective 3: Enhance data systems to drive quality improvement

Rationale: The flow of information through the system that captures immunisation/vaccination coverage is key to knowing how to intervene and whether interventions are successful.

Unfortunately, granular local data necessary for a comprehensive understanding of vaccine uptake across the borough are not currently unavailable. The City and Hackney Immunisations Data Review identified a number of vaccination specific data gaps related to socio-demographics, geography and key inclusion groups for both routine and seasonal vaccination programmes.

Vaccination data for Hackney and the City of London is also combined. Disaggregated data for these markedly distinct areas is needed to identify the specific needs of each borough. Focused actions to influence the system to provide separate data sets are essential.

Objectives: We aim to improve immunisation data quality and granularity for City and Hackney. We are working closely with NEL ICB and partners to introduce an integrated dashboard that enables bespoke and detailed analyses of local vaccination data, disaggregated for Hackney and the CIty of London. This will facilitate more targeted activity towards population groups with low vaccination coverage as well as the ability to evaluate initiatives to improve uptake.

Another key objective is to improve access to data sharing agreements to enhance vaccination campaigns, in particular school programmes, and reduce the numbers of individuals that are not registered with a GP.

Having a separate workstream to ensure progress of data quality and improvement will enable a smoother process and more accurate immunisation overview for City and Hackney. Enhanced systems and quality will also enable regular monitoring & evaluation of campaigns and initiatives listed with this strategic action plan.

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5.4 Strategic Objective 4: Optimise service delivery through evidence-based practice, system-feedback, and resource planning

Rationale: There is a need to enhance the effectiveness of immunisation programmes delivered at a place-based level. Audits have highlighted variations in the implementation of best-practice approaches (such as call/recall) across GP practices. A high proportion of did not attend (DNA) cases continues to impact on the effectiveness of call/recall activity, compounded by a lack of protected time to address vaccine concerns with patients. Opportunities for opportunistic vaccination or awareness raising as part of MECC have been impacted by competing needs across system partners and high-turnover of staff. Delivery of some immunisation services e.g. school-age immunisations, are dependent on collaboration with wider system partners, and may benefit from additional support. Finally, reflecting from COVID-19 and current outreach activity, we know the value of using locations where people are already accessing services, or where large numbers of people who are eligible for particular vaccinations come together.

What's been working well: We have observed that providing a more holistic health offer (which may include general health checks, oral health support and access to various health professionals) alongside immunisations has been more effective and engaging than offering vaccinations alone. Primary Care Networks have facilitated 'family fun day' events since 2023. Events within City and Hackney have attracted national recognition with case studies included in the NHS Vaccination Strategy (2023) and showcased on BBC News platforms. (8) (15)

Objectives: We aim to implement a comprehensive vaccination delivery network that includes routine, targeted and seasonal vaccinations across the lifecourse, as well as outbreak response and catch-up campaigns, through the locations and settings that best meet the needs of the local population. This network will include a standard 'universal and core offer', that is tailored to local communities, and supplemented by bespoke and targeted outreach interventions for specific populations currently underserved. We also aim to support GP practices and the school-age immunisation service (SAIS) provider in overcoming barriers to drive quality improvement and optimised service delivery.

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5.5 Strategic Objective 5: Provide guidance, training and development across the system as part of the approach to Making Every Contact Count.

Rationale: Making Every Contact Count (MECC) is an approach to behaviour change, utilising day-to-day interactions, to empower individuals to make positive changes that improve their physical and mental health and wellbeing. Immunisation programmes in England are delivered across the lifecourse and by multiple providers, providing protection from the prenatal stage to old age. Healthcare professionals therefore have an important role in promoting immunisations through MECC.

A MECC approach offers an opportunity to address the multiple challenges to vaccine uptake locally (identified by local insight work). Identified challenges include unawareness and misunderstanding of the routine immunisation schedule and eligibility criteria, as well as lack of knowledge regarding existing provision channels and access. Additionally, preferences for delayed immunisation and issues with GP registration and access are prevalent, with transient groups (including those new to the UK) at greater risk of not accessing mainstream health and vaccination services. Nonetheless, these groups may come into contact with other service providers or settings that offer broader wellbeing support (such as educational or children and family hub settings), presenting an opportunity to receive vaccination communication from non-health workers.

What's been working well: We will continue to engage and work with system-partners; including healthcare professionals, service providers, communities and voluntary sector organisations; to raise awareness of the importance of immunisations and support confident and consistent interactions with local populations utilising a MECC approach. This work is underpinned by reviewing training needs and developing supportive resources, including bespoke resources for specific VPDs such as measles. As well as ensuring immunisations are adequately covered in the general MECC training, we will input into the planned CYP MECC training development to ensure immunisations are a key focus.

Objectives: Our objective is to provide guidance, training and development across the system as part of the approach to MECC. To achieve this objective, we will conduct a thorough mapping exercise of services and settings interacting with eligible groups across the lifecourse. We aim to establish partnerships and embed immunisation champions within these settings. We recognise potential confidence barriers in communicating vaccine messaging, and we will address them by providing (and addressing) specific training needs as appropriate. This approach will ensure that both clinical and non-clinical staff are equipped to navigate confident conversations around immunisations and can effectively signpost eligible groups to local channels of provision.

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5.6 Implementation and Evaluation

5.6.1 Implementation Timeline

Our ambition is to deliver the strategic action plan over three years, between 2024 and 2027 (Fig. 6). The timeline affords us the opportunity to implement, assess and evaluate short-term achievements, ensuring that findings inform future iterations of this plan. Priorities each year have been set (Section 6), recognising that some actions are contingent on completing intermediary steps, and factoring feasibility, current priority levels and existing progress towards objectives.

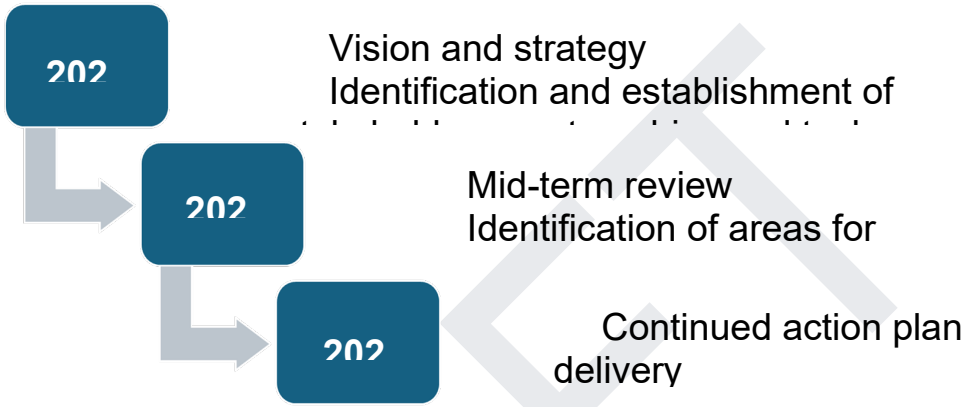

Figure 7. Implementation timeline.

5.6.2 Evaluation Framework

We will ensure that progress and challenges are effectively communicated to stakeholders as outlined in the governance structures (Chapter 4.2). As a living document, the plan and its deliverables, will undergo continuous process evaluation. The plan will be delivered over a three-year period (2024-27) with a mid-term review scheduled for 2025 (Fig. 6), to assess progress towards achieving key outcomes. Specifically, the evaluation will consider the extent to which:

- inclusion health and at-risk groups have been identified, and the effectiveness of targeted interventions to address barriers to uptake;
- data processes have been refined or established to inform activity and drive quality improvement in service delivery;
- immunisations have been embedded as part of MECC.

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6. The Strategic Action Plan

Strategic priority 1: Reduce inequalities in immunisation coverage among inclusion and high-risk groups				
Outcome	ID	Actions	Lead	Year
Enhanced outreach offer	1.1	**Map current vaccination & immunisation offer for all identified cohorts.** Identify points of contact for at-risk groups and collaborate with key stakeholders to promote existing services and offers, building towards long-term sustainable plans.	Imms Programme Manager & Public Health	2024-25
	1.2	**Prepare for the delegation of vaccination commissioning responsibility to ICBs and be prepared to bid for and/or utilise any additional funds** that are made available for reducing inequalities in immunisation rates. Considerations include building on the success of local GP provider outreach campaigns, evaluating the effectiveness of launching a mobile outreach initiative to improve access, community-led outreach and integrating vaccination offers into existing prevention and inequalities workstreams and services.	Public Health, NEL ICB & Lead providers	2024-27
Improved communication pathways and channels with inclusion and high-risk groups	1.3	**Establish an annual outreach calendar and communications plan,** incorporating seasonal campaigns. Identify the most effective communication approaches for inclusion health and high-risk groups, and regularly share campaign and event information to all key partners.	Lead GP provider & Public Health comms	2024-27
	1.4	**Establish and facilitate a high-risk and inclusion health group immunisations forum** to disseminate information on the latest infection risks, campaign offers and targeted outreach opportunities. Encourage dialogue among system-partners, including volunteer and sector organisations, to strengthen partnerships and support the adoption of **peer-led approaches.**	Imms Programme Manager & Public Health	2024-27

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Strategic priority 2: Engage local communities to build trust and cultivate a co-productive approach				
Outcome	ID	Actions	Lead	Year
Strategic mapping and establishment of communication and engagement channels	2.1	**Determine scale of vaccination inequalities and equity** within the routine childhood immunisation programme to inform communication and engagement prioritisation.	Public Health	2024-25
	2.2	**Undertake needs assessment** to inform a population level strategy for vaccination of **GBMSM**.	Public Health	2025-27
	2.3	**Map touch points throughout the lifecourse** to identify **channels for awareness raising and engagement activity** e.g. collaboration with voluntary and community sector groups, faith settings and parent groups	Public Health	2024-25
Strengthened partnership working centred on people and community	2.4	Work closely with the community champions programme to **ensure champions are empowered to raise awareness of vaccinations** and signpost to local provision. **Establish a feedback framework** to engage community champions and other key stakeholders (such as children and family hubs), ensuring that insights inform vaccine programme and campaign delivery.	Community Champions Programme & Public Health	2024-25
	2.5	**Engage with newly established London-wide vaccine steering groups** (VSGs) **to gather insights** and incorporate into community engagement work at a place-based level. As of 2024 the current community vaccine groups are Black African, Black Caribbean Christian Faith Group, Bangladeshi, Eastern European and Somali.	Public Health	2024-27

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	2.6	**Continue engagement and enhanced access in the North East of Hackney.** Expand community members involved in engagement and uptake initiatives. Continue to evolve enhanced access offers based on community insights and feedback, to maximise vaccination coverage.	Imms Coordinator & Programme Manager, NE PCN	2024-26
Co-produced initiatives	2.7	Commit to **establishing relationships and building trust** with key communities with low vaccine coverage and work towards **developing co-produced interventions and resources** tailored to target communities.	Public Health, Healthwatch	2025-27

Strategic priority 3: Enhance data systems to drive quality improvement				
Outcome	ID	Actions	Lead	Year
Improved data quality and accessibility	3.1	**Establish a City and Hackney data immunisation sub group.** This group will work through data gaps identified in the data appendix (e.g. disaggregating City and Hackney data) by advocating at local, regional and national forums. This group will work to improve ways to access data both routinely and during outbreak scenarios.	PHIT	2024-25
	3.2	**Enhance school immunisation coverage data.** ● Map out and clarify data flow pathways for school immunisation programmes working to support CHIS link school information. ● Improve consistency of records of school immunisations working with vaccination UK and GP teams.	Imms Programme Manager, CHIS, PHIT	2024-25
	3.3	Work closely with the **NEL ICB data team** to optimise data improvement work. This includes shaping the NEL dashboard to ensure usability at local levels and utilise it to	PHIT & NEL ICB	2024-25

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		support the development of insight reports and facilitate evaluations of initiatives.		
Regular monitoring & evaluation	3.4	**Monitor the available data sources.** Review key data sources (e.g. CEG, Immform, NEL dashboard) and share an insights report on a quarterly basis for childhood immunisations and more frequently during seasonal campaigns for COVID & Flu. Use the above data sources to carry out evaluations.	Imms Programme Manager, Primary Care	2024-27

Strategic priority 4: Optimise service delivery through evidence-based practice, system-feedback, and resource planning				
Outcome	ID	Actions	Lead	Year
Increased number of immunisation quality improvement initiatives within City and Hackney	4.1	1. **Conduct GP practice visits** to identify areas for quality improvement, share best practices (including promotion of the City and Hackney GP toolkit) and gather insights. 2. Enhance the **immunisation bulletin** and facilitate **regular drop-in sessions** for ongoing support, discussion and information exchange.	Imms Clinical Lead, Imms Programme Manager, Imms Coordinator	2024-25
Promotion of best practice call/recall approach	4.2	1. **Develop a call/recall strategy** informed by recent campaigns. 2. Promote **adoption of the APL Imms software** as a best practice approach to support call/recall activity and timely uptake of childhood immunisations. 3. Continue promotion of methodology where healthcare professionals	Imms Clinical Lead, Outreach providers, Homerton Maternity team	2024-25

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		reach out to patients following an initial decline, to address concerns and provide information. 4. **Share** insights and **successful best-practice outcomes** among system partners.		
Enhanced governance and feedback over schools based vaccination delivery	4.3	**Develop a school-age immunisation sub-group** to aid routine feedback and information exchange among key stakeholders involved in the coordination and delivery of the school-age immunisation programme.	Public Health	2024-25
Improved understanding of preferred community clinics for residents	4.4	**Evaluate previous venues used for outreach/vaccination in community spaces** to date, including those during the pandemic. Explore new sites for vaccination, including collaborating with Children and Family Hubs and healthspot and community pharmacy, to support a venue strategy that meets the population's needs and maximises reach.	Imms Programme Manager, Community Pharmacy	2024-25
Effective resource planning and management to enable the delivery of this action plan as well as to prepare for devolved commissioning arrangements	4.5	Effective **resource planning** and management to **enable the delivery** of actions within this strategic plan: ● continuing to advocate for sustained and, where possible, increased funding for local immunisation activities in line with this action plan, including resources to develop and coordinate campaigns and engage with communities; ● preparation for the effective use of non-recurrent funding streams when these are made available; and ● coordination activities across key system partners and established governance structures to support effective and efficient resource planning and management.	NEL ICB Public Health Primary Care Acute Trust	2024-26
	4.6	**Preparation** for the **delegated responsibility** for **commissioning** NHS vaccination services to ICBs: ● review current structures and ensure robust governance mechanisms are in place to support the devolved funding structure; ● plan for changes needed to accommodate devolved budgets, including	Primary Care Public Health SHRS Acute Trust	2024-26

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		adjustments to existing processes and procedures; ● plan for appropriate providers and delivery mechanisms that align with the specific needs of the population; ● assess the resource implications, including workforce planning; and ● set clear deliverables against the action plan.		

Strategic priority 5: Provide guidance, training and development across the system as part the approach to Making Every Contact Count.				
Outcome	ID	Actions	Lead	Year
Immunisation advocacy and signposting within commissioned services and existing partnership	5.1	**Map commissioned services** (e.g. social prescribers, health visitors, early years, sexual health service, libraries, leisure centres etc) that interface with eligible cohorts, to **establish vaccination communication and engagement channels**.	Public Health	2024-25
	5.2	**Provide support** to commissioned services in appointing staff members (including those from specific community backgrounds) **to champion immunisations** proactively through MECC.		2025-27
	5.3	**Leverage existing platforms to disseminate information** and engage key stakeholders in the community around vaccination, ensuring coordinated efforts through Public Health Community Engagement Streams, Healthwatch and the		

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		Integrated Commissioning Groups.		
	5.4	**Maintain connections** with community organisations established during the COVID-19 pandemic.	Community Champions Programme	2024-27
	5.5	**Develop a language guide** to support confident vaccination communication in education and early years settings.	Public Health, Early Years	2025-27
Training and resources for both clinical and non-clinical system-wide partners	5.6	Consider the scope of **training for non-clinical and clinical staff**, and identify existing training, learning platforms and resources (e.g. Jitsu-Vax) that can be used or adapted to address the specific needs of these groups (e.g. community leaders, sexual health and reproductive personnel, GP administration etc).	Public Health, Imms Clinical Lead, Sexual Health Services	2025-27
	5.7	**Integrate immunisation in broader health literacy resources** and **Council-led MECC training**.	Population Health Programme	2024-25

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City and Hackney Health and Care Board

13 November 2024

Title of report	North East London ICS Anti-Racism Strategy
Author	Joseph Lee – Senior Strategy Manager
Presented by	Lee Walker
Contact for further information	Lee Walker, Head of Strategic Planning and Impact
Executive summary	This paper provides an overview of the initial work to create a North East London ICS anti-racism strategy. The development of an anti-racism strategy is a continuation following on from the system anti-racist workshop convened in October 2023 and aims to build on anti-racism work already taking place in our organisations and partnerships. The overarching aim of the work is to co-create a joined-up strategy for the system without replacing or duplicating existing anti-racism initiatives. The strategy is being steered by a group of system representatives that includes NEL Trusts, Local Authorities, Healthwatch branches and VCSEs. Diane Jones chairs the group and is overseeing the development work. The strategy focuses on three key areas (listed below) and lists a selection of areas of focus for organisations to further develop within a wider anti-racist approach and includes case examples of work within north east London. The three pillars of the strategy are: • Workforce and leadership • Our approach to anti-racism • Ethnic inequalities in health
Action / recommendation	The Board/Committee is asked to: note the contents of the paper which deals with progress to date and comment on the draft strategy document
Previous reporting	N/A
Next steps/ onward reporting	The strategy will be taken to the ICB board in January 2025 for sign off and publication.
Conflicts of interest	None
Strategic fit	Which of the ICS aims does this report align with? • To improve outcomes in population health and healthcare

	• To tackle inequalities in outcomes, experience, and access
Impact on local people, health inequalities and sustainability	We hope through the development of the strategy, and subsequent ICB action plan, that we will be able to increase the cultural sensitivity of our staff and services and reduce the inequalities in access, experience, and outcomes.
Has an Equalities Impact Assessment been carried out?	No EQIA. The anti-racism strategy is work that seeks to identify patient, resident or staff groups that are disadvantaged because of race at the present time, and then reduce that disadvantage at the system wide level. Therefore, we have not anticipated that a protected characteristic group will be more disadvantaged (than they currently are already) by the development and implementation of this strategy
Impact on finance, performance and quality	There is no current financial request aligned to the development of the strategy, however further work within the ICB, as a result of the strategy, may require financial resources to deliver.
Risks	Evidence shows that the racism built into our structures and cultures is linked to poorer health outcomes for both physical and mental health. ICBs have a statutory duty to tackle health inequalities and over half of half north east London's population are from Black, Asian and minority ethnic backgrounds. There is a risk that failing to address these sets of drivers that leave the majority of our population at risk of poorer outcomes which would lead to worsening inequalities for these groups. Having initiated the anti-racist workshop in autumn 2023 it has been asked by stakeholder what had happened to the outputs from that event and what had been happening. There would be a risk to the ICB if it did not give a system partners a clear way forward on anti-racism and while it does not specifically need to follow the approach outlined here an alternative process would be required to mitigate this risk.

1. Introduction

The population of north east London is hugely diverse by ethnicity, country of birth and language. More than half (53%) of NEL's population is made up of people of the global majority (all ethnic groups except while British and other white groups), compared with 18% across England overall.

In autumn 2023 NHS north east London brought together a system workshop to build on the anti-racist work that already takes place in some of our organisations and partnerships to co-create a joined up, overarching strategy. This strategic development work provides continuity with the previous system wide work the ICB had coordinated last year.

2. Proposed approach

The development of an anti-racism strategy will be built upon three core pillars of work within the ICB and across the ICS and look to work across all areas of the ICSs functions, focusing particularly on our system priorities for improving quality and outcomes and tackling health inequalities.

Strategy pillars

1. Workforce and leadership
2. Our approach to anti-racism
3. Ethnic inequalities in health

The ICS strategy will not replace any single-agency initiative but aims to build upon the work across the ICS and bring together all partners to a set of system wide aims that will address racism and its impact, across north east London.

3. Steering Group / Task and Finish Group Approach

A steering group, and task and finish group, have been established to develop the strategy, engage with system partners and build on the best practice already established within north-east London. The steering group is established to have more oversight and sign off of the strategy as it is drafted, and the task and finish group is there to develop the detail of the content. Both groups are chaired by Diane Jones and the membership of the group is majority system partners not ICB staff. The T&FG meets weekly and are working in an agile way, refining, and coproducing content together.

This group has representation from across Place, Local Authorities, Provider organisations, VCSE collaborative and Healthwatch. Several Chief People Officers are being copied into the meeting papers to keep them informed.

The members of the T&FG and the SG have been asked to engage with their own organisations on the strategy to ensure support.

4. Governance and engagement

Overall sign off will be by the ICB Board in January 2025. We are taking the strategy to the ICB Executive Committee and the ICP Committee for endorsement in January 2025.

Each provider and LA representative in our SG and T&FG are asked to get endorsement from their organisation for the strategy.

Engagement to date has been focused on the weekly task and finish groups as we have tested the approach and content with the members of the T&F Group from our system partners. In addition there has been engagement with ICB staff through a number of events focusing on the strategy through Black History Month.

Further engagement has taken place with ICB staff, a specific VCSE place session and a session is planned with our ICB BME Network.

5. Principles from the Steering Group

A set of draft principles were developed, following feedback from the initial task and finish group to demonstrate that the strategy will complement existing organisational initiatives as well as look to set some aspirations goals for the ICS to work towards.

- Will build on, and magnify, the current work across the system within individual organisations
- Not duplicate or replicate current work within individual organisations
- The strategy will focus on areas which will be meaningful and impactful to deliver real change
- Not create unnecessary additional bureaucratic burden on organisations

It was immediately clear that we have system partners who have already made much progress on anti-racism and are very comfortable in sharing the achievements that have already been made and that the strategy would not need to try to replace good work already happening although it could attempt to raise the profile of that activity.

6. Draft strategy

The current strategy has been written in conjunction with the task and finish group to demonstrate the activities that the system needs to undertake

There has also been developed a strategy mission and vision for north east London to become ant racist:

6.1 Strategy mission - To ensure that north east London ICS is an anti-racist, equitable and positive place to live and work in.

6.2 Strategy vision - Working together, and with our communities, we will identify and address areas across north east London which may contribute to the continued systemic racism and health inequity that adversely affects the people of north east London. We will work with partners to deliver strategies and initiatives for tackling structural and systemic racism, and we will work towards embedding this approach across all we do as providers of health and social care.

The strategy aims to confirm that this work is needed as part of a wider social and economic measures that look at the wider determinants of health and addressing issues or inequalities.

We acknowledge that inequalities are present across a broad range of characteristics and whilst we acknowledge these, this strategy focuses solely on the impacts of health related inequalities related to race.

6.3 Pillars and areas of focus

The strategy has been developed around three pillars, with several areas of focus for anti-racist initiatives we will deliver as a system to address systemic and institutionalised racism across our organisations.

- Workforce and leadership
    - Talent programmes for underrepresented staff at senior levels
    - Increasing the diversity of our board by 2035
    - Mandatory racial bias, EDI, or cultural sensitivity training for staff
- Our anti-racist approach

- Amending the service design process to remove the cause of any inequalities
- Ensure our providers have the same anti-racist principles
- Looking to standardise the use of the increased ethnicity coding

- Ethnic inequalities in health
    - Providing culturally sensitive services to reduce inequalities
    - The ICB to convene an annual anti-racism summit to share best practice
    - Utilise our community insights and engagement to shape services

Pillar	Leadership and workforce	Anti-racist ways of working	Health equity
Summary	• Ensure that the behaviours of our leaders and staff reflect our commitment to being anti-racist and ensure that, at every level, our organisations are representative of local people	• Organisations will maximise leverage against racism through they work, design and deliver services	• People within north east London will not be disadvantaged because of their race
Commitment	• Being an anti-racist system which has an anti-racist approach to the ways we work • Support our staff and create enabling workplaces	• Redesign the processes we use to procure services proactively to support they work against racism • Ensure that our services meet our shared standards of anti-racist practices	• Prioritise and deliver evidence informed, culturally competent interventions • Reduce inequities people from ethnic minority groups face in access, experiences and outcomes of our services
Proposed areas of focus	The NEL system develops a talent programme for underrepresented staff groups NHS organisations: board of directors' diversity by ethnicity must match closely the diversity of the workforce and population served as a whole by 2035 Organisations implement mandatory EDI / Cultural sensitivity training / anti-racism training and embed anti-racism in our learning and development	When re-designing service pathways and writing service specifications require commissioners to assess which ethnic groups of service users are not accessing services Use procurement to ensure all potential providers have anti-racist statements and anti-racist policies Ensure ethnicity is recorded at every patient contact and ensure that the reasons for recoding ethnicity is explained to patients	Develop and deliver integrated and personalised care that is culturally sensitive using methods such as service co-location, case management, and patient collaboration or personalised care Organise an annual anti-racism summit where the NEL system holds itself to account Support community groups from ethnic minority communities to engage effectively in procurement and commissioning processes Data-led insights to prioritise areas of work to address these insights with community groups

7. Next steps

We will continue to develop and engage with partner organisations and the task and finish group regarding the anti-racism strategy prior to submission to the ICB board in January 2025.

While the anti-racism strategy will push ahead on anti-racism work across north east London it will not be a granular action plan that the system partner organisation could follow to progress intra-organisational anti-racism work.

After this strategy is published, there is likely to still be a need for a wider equality, diversity and inclusion action plan that would take forward the ICBs anti-racism work.

8. Appendix A – Draft NEL ICS anti-racism strategy

Attached is the full draft NEL ICS anti-racism strategy for comments. When approved, further engagement will take place as per section 4, and then brought back to the ICB EMT ahead of formal sign off through our governance in January 2025.

9. Appendix B – Attendance list

A distribution list is included to highlight the engagement and attendance at the Task and Finish / Steering Groups

Appendix A - Draft NEL ICS anti-racism strategy

Draft NEL ICS anti-racism strategy attached as an accompanying document

Annex B:

Attendance List

Local Authority EDI Leads *Head of equality diversity and inclusion*	**Name**	**Email**
Barking and Dagenham		
City of London		
Hackney	Rebecca Dyer, Workforce, Equality and Inclusion Officer Deborah Barnett, Head of Equality, Equity, Diversity, Inclusion & Belonging	[redacted]
Havering		
Newham	Paul Kitson as Corporate Director of Inclusive Economy	[redacted]
Redbridge		
Tower Hamlets	Damian Roberts, Head of Equalities and Inclusion	[redacted]
Waltham Forest	Joy Hume, Head of Equality, Diversity and Inclusion	[redacted]

Local Authority Education Leads (5-18 years)		
Barking and Dagenham		
City of London	N/A	N/A
Hackney		
Havering	Trevor Cook, Assistant Director of Education Services	[redacted]
Newham		
Redbridge	Colin Stewart, Director of Education	[redacted]
Tower Hamlets	Lisa Fraser, Director of Education	[redacted]
Waltham Forest	Cheryl Eyre, Education Advisory Services	[redacted]

Healthwatch		
Barking and Dagenham	Manisha Modhvadia, Manager	[redacted]
City of London	Rachel Cleave, General Manager	[redacted]
Hackney	Catherine Perez Philips, Deputy Director of Operations	[redacted]

Havering	Ian Buckmaster, Executive Director	[redacted]
Newham	Veronica Awuzudike, Manager	[redacted]
Redbridge	Cathy Turland, Chief Executive Officer	[redacted]
Tower Hamlets	Matthew Adrien, Service Director	[redacted]
Waltham Forest	Dianne Barham, Chief Executive	[redacted]

Primary Care Leads (Clinical)		
Barking and Dagenham		
City of London		
Hackney		
Havering		
Newham		
Redbridge	Dr Jyoti Sood, NEL Training Hub Clinical Lead	[redacted]
Tower Hamlets	Dr Farah Bede, Clinical Lead	[redacted]
Waltham Forest		

Community (Providers)		
Homerton	Victoria Beckwith Equality Diversity and Inclusion Lead at Homerton University Hospital	[redacted]
Homerton	Alesia Waterman, Deputy Director of People	[redacted]
Homerton	Basirat (Bas) Sadiq (copied for information only)	[redacted]
Homerton	Tom Nettel, Chief People Officer (copied for information only)	[redacted]
C&H Neighbourhoods	Angela McCalla, Neighbourhoods Partnership and Workforce Project Manager	[redacted]
Tower Hamlets Together	Roberto Tamsanguan, Clinical Director	[redacted]
Tower Hamlets Together	Ashton West, Tower Hamlets Together Partnership Lead	[redacted]
Tower Hamlets CVS	Najnin Islam, VCSE Collaborative NEL	[redacted]

Mental Health (Providers)		
NELFT	Harjit Bansal, Cherrise Chand, Cathrine Lund, of the Equality Diversity & Inclusion (ED&I) team	[redacted]
NELFT	Yvonne Hood, Deputy Director of People & Culture	redacted
NELFT	(copied for information only)	Equality&diversityadmin@nelft.nhs.uk
ELFT	Tanya Carter, Chief People Officer (copied for information only)	[redacted]
ELFT	Barbara Britner, Deputy Director of People and Culture	[redacted]
ELFT	Juliana Ansah, Head of Equality, Diversity & Inclusion	[redacted]
ELFT	(copied for information only)	elft.edi-team@nhs.net

Acute (Providers)		
BHRUT	**Janine La Rosa** Chief People Officer	[redacted]
BHRUT	**Alan Wishart, Interim Director of Workforce**	[redacted]
BHRUT	Remi Odejinmi Director for Equality, Diversity, and Inclusion	[redacted]
BHRUT	Temilola Smith, Deputy Matron	[redacted]
Barts Health	Olayinka Iwu has joined Barts Health as our new associate director of inclusion.	[redacted]
Barts Health	Anthea Bart, Head of Community Participation, Whipps Cross University Hospital	[redacted]
Barts Health	Delvir Mehet, Group Director of People (copied for information only)	[redacted]

Miscellaneous		
Diane Jones	Chief Nursing Officer	[redacted]
Hannah Harniess	Director of Allied Health Professionals	[redacted]
Anna Carratt	Deputy Director of Strategic Development	[redacted]
Ellen Bloomer	Public Health Consultant / Health Inequalities Lead	[redacted]
Lee Walker	Head of Strategic Planning and Impact	[redacted]
Joseph Lee	Senior Manager Strategy	[redacted]
Archna Mathur	Director of Specialised Services and Cancer	[redacted]
Adeola Agbebiyi	Deputy Director of Public Health	[redacted]
Anna Garner	Head of Performance and Population Health for City and Hackney at the ICB	[redacted]
Julie Dublin	Chair BME Network	[redacted]
Daksha Desai	Interim Organisational Development Consultant	[redacted]
Robert Sinfield	Senior Lead, Data Insights	[redacted]

NEL anti-racism strategy

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Introduction

Racism continues to be a significant issue that deeply impacts the health and well-being of our diverse communities. The inequalities experienced by individuals facing racism are unacceptable and must be addressed through collective action.

To address persistent racialised health inequalities, it is imperative to embed anti-racist ways of working within the operations of our work as an Integrated Care System (ICS). Anti-racist work should be an integral service improvement tool aimed at reducing racial inequalities and moving towards health equity.

North East London Health and Care Partnership (NELHCP) is committed to becoming an anti-racist system and will continue to evaluate and monitor our efforts to ensure these positive changes become embedded into our organisational and system culture across our partners. We will:

- Work with our leadership and workforce, ensuring that the behaviours of our leaders and staff reflect our commitment to being anti-racist and ensure that, at every level, our organisations are representative of local people.
    - Being an anti-racist system which has an anti-racist approach to the ways we work.
    - Support our staff and create enabling workplaces.
- Ensure our approach to anti-racism, maximises our leverage against racism.
    - Review the processes we use to design and procure services, so they proactively support the work against racism.
    - Ensure that our services meet our shared standards of anti-racist practices.
- Review ethnic inequalities in health and ensure residents are not disadvantaged because of their race.
    - Prioritise and deliver evidence informed, culturally competent interventions.
    - Reduce the inequalities people from ethnic minority groups face in access, experiences, and outcomes of our services.

We acknowledge the need to tackle all forms of discrimination and inequalities and addressing systemic racism remains a critical priority for the organisations of north east London health and care partnership. It is important to recognise our anti-racist work within a comprehensive framework of equality and inclusion, whilst emphasising its prominent role in addressing some of the systemic causes of inequalities and that by addressing these issues, we can create a system that enhances outcomes for all staff and patients.

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Foreword

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Diane Jones
Chief Nursing Officer
NHS North East London Integrated Care Board

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Background

In autumn 2023 NHS north east London (NEL) Integrated Care Board (ICB) brought together a system workshop to build on the anti-racism work that already takes place in some of our organisations and partnerships, to co-create a joined up, overarching approach.

Drawing on best practice from across the ICS and nationally, north east London proposes to adopt a model that emphasises the following elements:

- A clear and robust leadership commitment to anti racism, with role models across the system.
- Supported by:
  - The right resources and enablers (data, governance, partnerships, financial and people resource); and
  - Consistent messages and constant engagement and feedback
- With progress assured and reflected through:
  - Celebrating and evidencing success; and
  - Accountability and metrics
- The partners will work collaboratively to tackle racism as well as continuing to work individually.

The development of an anti-racism strategy will be built upon three core pillars of work within the ICB and across the ICS which look to embed across all areas of the ICSs functions, focusing particularly on our system priorities for improving quality and outcomes and tackling health inequalities.

The ICS strategy will not replace any single-agency initiative but aims to build upon the work across the ICS and bring together all partners to a set of system wide aims that will address racism and its impact across north east London.

Our mission

To ensure that North East London ICS is an anti-racist, equitable and positive place to live and work in.

Our vision

Working together, and with our communities, we will identify and address areas across North East London which may contribute to the continued systemic racism and health inequalities that adversely affects the people of north east London. We will work with partners to deliver strategies and initiatives for tackling structural and systemic racism, and we will work towards embedding this approach across all we do as providers of health and social care.

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This strategy contributes and build upon the work towards an anti-racist approach across London and north east London ICS agrees with and has signed up to the London ICS's anti-racist commitment:

London ICS's anti-racist commitment

- The Chairs and CEOs of London's five Integrated Care Boards would like to express their commitment and support to a strategic anti-racism approach in London's Health and Care System. We understand our role, not just as leaders of statutory NHS bodies, but as the conveners of Health, Care and Community Partners, in driving forward this agenda, and embedding race equity into being part of how our health and care system operates.
- We are deeply proud to serve in London's diverse systems, where this diversity is central to the prosperity, strength and energy of our collective delivery. As such, our ICBs have developed strategies for tackling structural and systemic racism and are working towards embedding this approach into our emerging integrated care strategies, joint forward plans and workforce planning. We recognise that we are on a journey to see differently, respond differently and lead differently in order to achieve our anti-racism ambitions. We are taking actions that fit our specific situations for example anti-racism training and development for our staff and establishing race equality groups to advise our boards in order to help close health and workforce equity gaps. We will continue to evaluate and monitor our efforts to ensure these positive changes become embedded into our organisational and system culture.
- We look forward to working with, sharing with and learning from our partners across London in addressing ethnic health inequalities, as part of our approach to addressing wider health inequalities, at every level of our system.

September 2023

Organisational pledges

North East London Health and Care Partnership is committed to bringing together all organisations to deliver real change and the purpose of this strategy is to deliver a consistent approach to the systemic issues that deliver worse outcomes for those from an ethnically diverse background who work and live within north east London.

As such the Chairs and Chief Executive Officers of the organisations within the ICS would like to express their commitment and support to this strategy, in order to send a clear message that we are united in working to reduce these inequalities and confirm that racism, in any form, will not be tolerated in our organisations and services.

Drafting Note: CEOS OF ICS ORGANISATIONS PLEDGES TO GO HERE

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North East London
Health & Care
Partnership


NHS
North East London


NHS
Barts Health
NHS Trust


NHS
Barking, Havering and Redbridge
University Hospitals
NHS Trust


NHS
Homerton Healthcare
NHS Foundation Trust


NHS
North East London
NHS Foundation Trust


NELFT
NHS
NHS Foundation Trust


Hackney


DOMINE DIRIGE NOS
CITY
OF
LONDON


TOWER HAMLETS


Newham London


Waltham Forest


Barking &
Dagenham

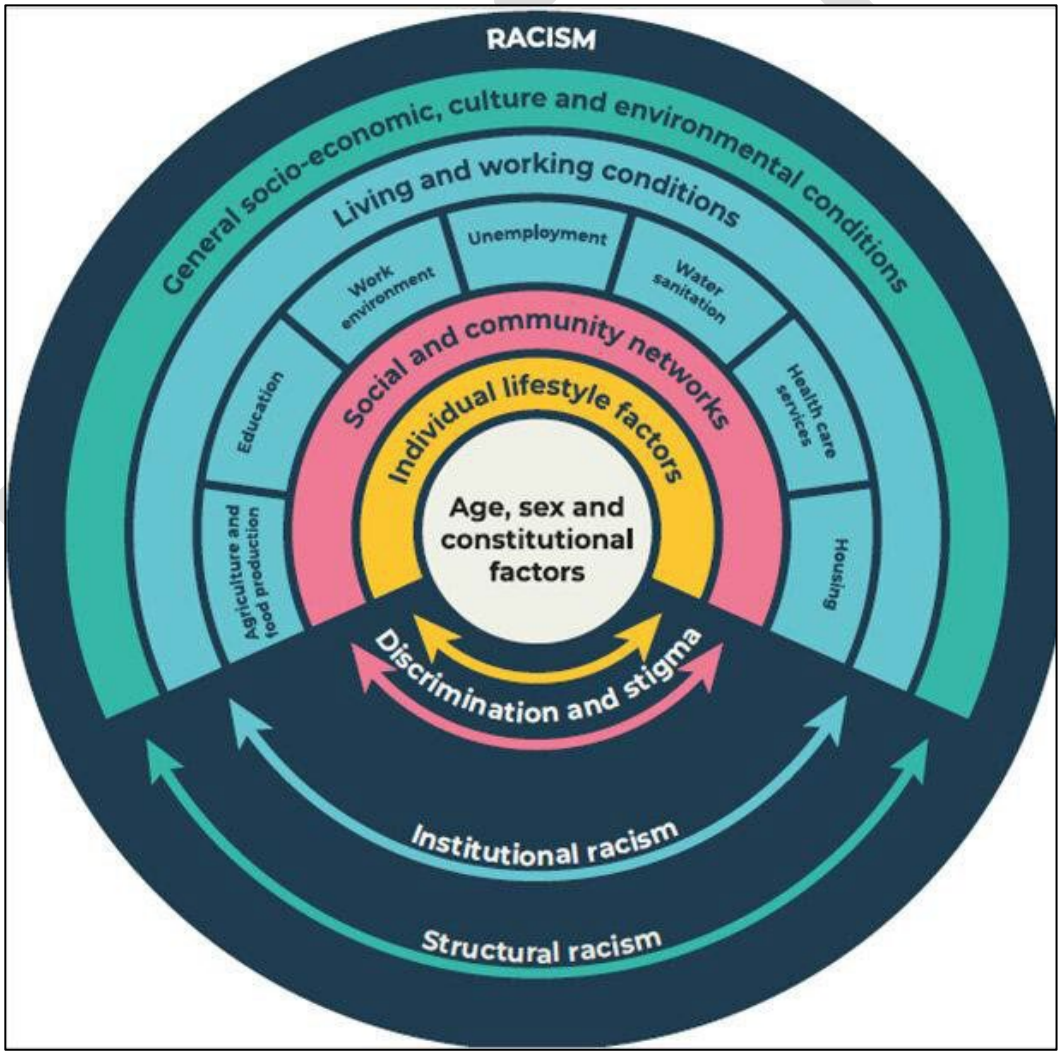

London Borough of
Redbridge


Havering
LONDON BOROUGH

Problem statement

Racism continues to be a significant issue that deeply impacts the health and well-being of our diverse communities. The inequalities experienced by individuals facing racism are unacceptable and must be addressed through collective action.

Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call “race”), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources – (Camara Jones)



[1]

[1] Yip, Jennifer & Poduval, Shoba & Souza-Thomas, Leah & Carter, Sophie & Fenton, Kevin. (2024). Anti-racist interventions to reduce ethnic disparities in healthcare in the UK: an umbrella review and findings from healthcare, education and criminal justice. BMJ Open. 14. 10.1136/bmjopen-2023-075711

It is our ambition that we will remove the structural problems that continues to deliver differences in health outcomes for our population with the goal of achieving health equity. Health equity is the assurance of the conditions for optimal health for all people and is achieved through the removal of health inequalities. We have collectively agreed, as part of our approach, to the following statements:

- **Racism exists**
- **Racism is a structural and systemic problem**
- **Racism impacts health outcomes**

Only once we have, as a system agreed to these statements, we can begin to identify how racism is operating and how best to address it. As a system we acknowledge that everyone has a responsibility to address racism, and it is part of everyone's roles across our organisations to become actively anti-racist.

We need to be accepting of the uncomfortable truth around the existence of racism in our organisations and our services and critically reflect on the systems and ways of working which have engrained systemic racism that perpetuate racial inequalities within our population.

We need to acknowledge that no one group, regardless of racial ethnicity, can claim to be completely anti-racist and accept that we need to be honest and transparent in the fact that we all have work to do to become more anti-racist and address the effects or racism within our system and population.

To address persistent racialised health inequalities, it is imperative to embed an anti-racist approach within the operations of our work as an ICS. Anti-racist work should be an integral service improvement tool aimed at reducing racial inequalities and moving towards health equity.

We need to go further than simply naming racism, we need to move to action and look to address the causes of inequalities within our system through collective action against these causes.

Definitions and language

The language we use helps to shape the understanding and representation of the groups within north east London who have experienced racism through the care or services they have received. It is therefore important that a set of agreed definitions and a common use of language helps to shape the approach to tackling racism within each organisation.

Definitions

Racism: is defined as a complex system of structuring opportunity and assigning relative value based on phenotypic characteristics (appearances), unfairly disadvantaging ethnic minority groups, and unfairly advantaging white people.[2]

Anti-racism: a powerful collection of antiracist policies that lead to racial equity and are substantiated by antiracist ideas," where an antiracist idea is "any idea that suggests the racial groups are equals in all their apparent differences"[3]

Systemic racism: racism that emphasises the involvement of systems, and often whole systems such as political, legal, economic, healthcare, education, criminal justice systems, and includes the structures that enforce these systems.[4]

Structural racism: the form of racism that is enforced by structures in society, including the laws, policies, institutional practices, and entrenched norms, and form the systems' scaffolding.[5]

Institutional racism: the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour that amount to discrimination through prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people.[6]

Health inequalities: avoidable, unfair, and systematic differences in health between different groups of people.[7]

Health equity: inequity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human

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[2] Jones CP. Confronting Institutionalized Racism. Phylon 2003;50(1-2):7-22
[3] Ibrahim X Kendi. How to be an antiracist. 2019.
[4] Systemic And Structural Racism: Definitions, Examples, Health Damages, And Approaches To Dismantling | Health Affairs
[5] Systemic And Structural Racism: Definitions, Examples, Health Damages, And Approaches To Dismantling | Health Affairs
[6] MacPherson Report (1999)
[7] What Are Health Inequalities? | The King's Fund (kingsfund.org.uk)

right. Health equity is achieved when everyone can attain their full potential for health and well-being. [8]

Personal / Interpersonal racism: this occurs during interactions between individuals and can include, making negative comments about a particular ethnic group in person or online, calling others racist names, and bullying, hassling or intimidating others because of their race.[9]

Trauma Informed Organisation: An organisation which has adopted and embedded the values and practices consistent with trauma informed approaches that are ways of working that support people recognised as having specific needs that are a result of past or ongoing trauma.

White fragility: the idea that some white people are upset and feel threatened when they think about or are told about racism (policies, behaviour, rules, etc. that result in a continued unfair advantage to some people and unfair or harmful treatment of others based on race).[10]

Cultural racism: is a form of racism (that is, a structurally unequal practice) that relies on cultural differences rather than on biological markers of racial superiority or inferiority. The cultural differences can be real, imagined, or constructed[11]

Medical racism: is the systematic and wide-spread racism against people of colour within the medical system. It includes both the racism in our society that makes people less healthy, the disparity in health coverage by race, and the biases held by healthcare workers against people of colour in their care.[12]

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[8] Health equity (who.int)
[9] Australian Human Rights Commission - ahrc_sr_2021_4_keyterms_a4_r2_0.pdf (humanrights.gov.au)
[10] White fragility - English meaning - Cambridge Dictionary
[11] Mukhopadhyay, Carol C.; Chua, Peter (2008). "Cultural Racism". In John Hartwell Moore (ed.). *Encyclopedia of Race and Racism*.
[12] Medical Racism & Antiracism - Multicultural Health - Research Guides at Stanford School of Medicine - Lane Medical Library

Language

North east London is a diverse population with many ethnicities and communities represented. In our use of language, we will aim to reflect racism in its widest context, appreciating that it affects all ethnically diverse communities and acknowledge that we may not always use language which is as reflective as we intend. As such we aim to follow the principles laid out by The NHS Race and Health Observatory[13].

Our principles

- We will always be as specific as possible about the ethnic groups we are referring to, only using collective terminology where there is a legitimate need to do so.
- We will avoid use acronyms or initialisms such as BME or BAME.
- Where collective terminology is needed, we will always be guided by context, and will not adopt a blanket term. In the event that the context is not decisive, we will use collective terms such as 'Black and minority ethnic', 'ethnic minority', 'Black, Asian and minority ethnic' interchangeably. This is to reflect the fact that no one term is suitable to all of our stakeholders and to respect individual and community dignity.
- We will always be transparent about our approach to language and be open to adapting our approach in response to feedback.

[13] NHS_RaceHealthObservatory_Terminology-consultation-report-NOV-21-1.pdf (nhsrho.org)

Overview of North East London

The population of north east London is hugely diverse by ethnicity, country of birth and language. More than half (53%) of NEL's population is made up of people of the an ethnically diverse background (all ethnic groups except while British and other white groups), compared with 18% across England overall and we are the most diverse ICS in the country.

With a population of over two million, it is the second largest health economy in England and our population is predicted to increase by 13% to 2.2 million by 2028. This growth is faster than the London average with the greatest growth at 20% expected in Newham.

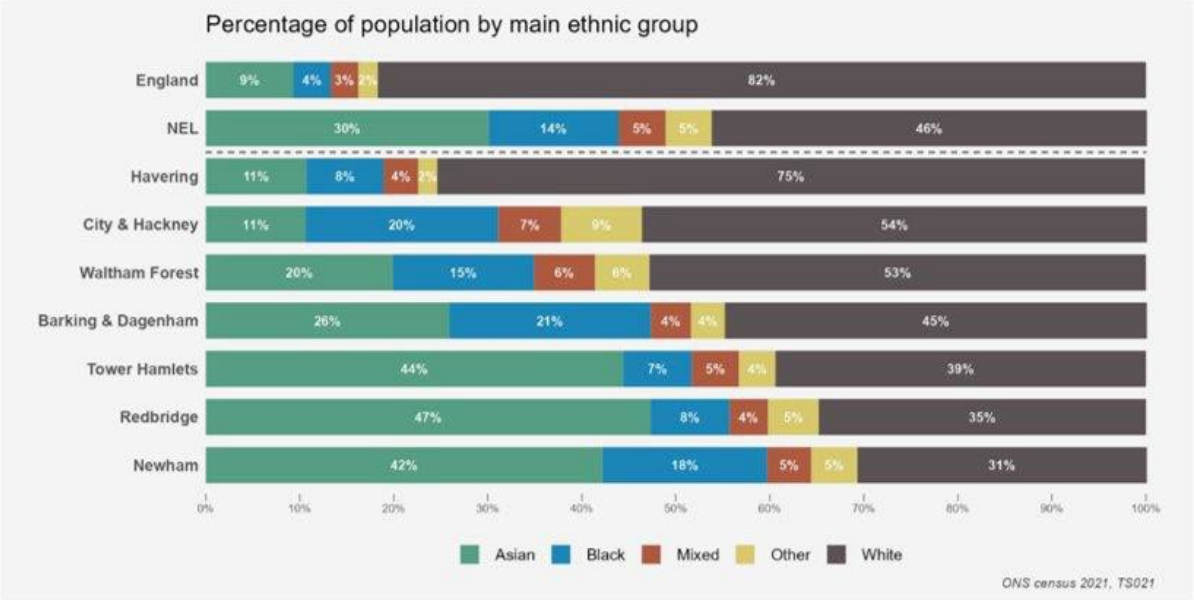

Figure 2 Percentage of population by main ethnic group (2021 ONS)

Our local communities are richly diverse with over 50% identifying as a Black, Asian or minority ethic groups. Four of our boroughs are in the top ten most diverse Local Authorities in England and Wales.

Five of our boroughs are in the twenty most deprived in England. Many local people rely on benefits, experience fuel poverty, unemployment and live in poor housing. There are significant variations across our boroughs in terms of health and care outcomes, population services and quality, between organisations and resources.

North east London is an area which has seen a huge deal of diversity over the past few decades and has some of the fastest growth of any London ICS within the coming years. Increasing diversity has been a core part of north east London, ever since the days of imperial rule and the importance of the docklands as the heart of global trade and colonialism.

North east London has a history as a place where people from a range of ethnic backgrounds were welcomed and able to contribute to the rich mix of ever-increasing diversity, bringing a wealth of benefits to local communities.

This however sits alongside a history of conflict and prejudice, as during the 1930s the East End was the focus of activity for Oswald Moseley's British Fascist Party, through to the 1970s and 1980 with a series of racially motivated murders and even as recently as the 1990s and 2006 with the election of British National Party (BNP) councilors in Tower Hamlets and Newham respectively.

As a population and a community north east London has consistently overcome this attempt to promote division and has celebrated the diversity that a rich complex set of cultures and ethnicities provides as a place to live and work.

North east London is a diverse and aspirant population and we as a system we need to put in place measures which will address systemic barriers, reduce racial health inequalities and enable the people of north east London to thrive.

Tackling racism and embracing the benefits of diversity in all forms, is at the core of our organisations and our people and therefore it is vital we continue to build on this work and take the next step in addressing some of the systemic causes and impact of racism on our population.

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Inequalities in North East London

Tackling health inequalities is a priority for the North East London ICS and is identified as a key cross-cutting theme in our first Integrated Care Partnership (ICP) Strategy.

The ICS will publish an annual health inequalities data summary for NEL on an annual basis to ensure that the data is used to drive change and improvements. This is intended to support ICS programmes and providers to build on their existing work identifying and acting on healthcare inequalities, particularly where cross-NEL and multi-sector action is required.

There are several key inequalities worth highlighting as part of this strategy[14]

- a higher proportion of people from the Asian ethnic group are waiting 18 weeks than might be expected, representing 30% of the total waiting list compared to the 21% proportion of Asians in the NEL population.
- those from a black ethnic background had a non-elective rate 16% higher than the NEL rate.
- Those living in the most deprived quintile experiencing a 14% higher rate of emergency admissions, than the rate for all people in NEL.
- people in the Black ethnic group experience emergency admissions at a rate statistically 14% higher than the NEL rate.
- across NEL, the rate of babies born stillbirth was higher for babies born to Black women (3.8 per 1000) and Asian women (4 per 1000) compared to the rate for those both to White women (2.6 per 1000). This compares with the national average of 3.8 per 1000 babies.

The identification and assessment of the causes of inequalities is a core component to the work of the ICS and central to this work will be the identification of race related inequalities. We need to continue this system approach to tackling inequalities but also look to extend the focus of our work to review the intersectionality between the causes of inequalities related to race, such as deprivation.

The NEL ICS is working to become a Trauma Informed Organisation, developing a violence reduction strategy, and adopting trauma informed ways of working. It is recognised that racism can be a source of trauma and so will be working to join up violence reduction and anti-racism work at organisation and system level.

[14] Annual Health Inequalities Information for NHS North East London – July 2024

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Case Example

Executive Summary of North East London Local Maternity and Neonatal System's Equity and equality strategy and action plan

We know from the women and families we see, there are health, social and economic inequities and inequalities for women of Black, Asian and Mixed Ethnic backgrounds and those living in the most deprived areas when accessing and experiencing maternity services. Our initial needs assessment looked at the data and outcomes for women in our communities and identified a number of clinical outcomes and experiences that were poorer for certain communities than others.

As part of our engagement and co-production in developing a strategy and action plan to help deliver improvements in this space, we worked with Healthwatch and Maternity Mates to better understand the experiences and expectations of the women in our care. By meeting women where they are, prenatally and postnatally, in a variety of community based settings, we were able to have rich discussions and gain a real insight into their experience of maternity services. By utilising face to face interviews, focus groups and survey responses, from maternity service users and staff, we were able to identify themes and areas for improvements.

The key themes focused on engagement, communication, information sharing and consent. It was evident that some difficult experiences and poor outcomes could have been different with more accessible information, stronger communication, greater cultural awareness and a trauma informed approach.

With these themes identified, an action plan has been developed, worked on collaboratively with maternity staff, public health colleagues, and Maternity Voice Partnership Chairs. The action plan will provide direction for the five maternity units in North East London to have an equity lens in all these areas. The action plan is not necessarily about creating something new, in terms of pathways, processes or ways of working, but creating a culture that looks to the diversity of our people and provides safe, equitable and personalised care regardful of this.

Alongside this equity and equality action plan, we will work with our maternity units on the priorities and actions from the Ockenden Report, CQC reports and the Women's Health Strategy, ensuring plans are working together to ensure Black, Asian and Ethnic minority women and those living in the most deprived areas, feel supported and listened to, and that outcomes for these women improve.

This strategy and action plan is the start of change over the next five years. It will need to be a living document that is adapted and developed over time as environments change. The action plan is an overview for North East London, understanding that our communities have different needs, and each maternity unit will need to develop a localised plan to fulfil these needs.

We are committed to working together, as a system, to improve equity for mothers and babies and race equality for NHS staff.

North East London Anti-racist Pillars

Work is already taking place across the system to address the cause and impacts of racism on our population. There are many programmes of work which have been set up to tackle racism, with these varying in terms of their scope and focus.

Our strategy will look to build upon these actions and agree a shared set of areas that organisations will work on, in order to make improvements for north east London as a place to work and receive health and care services.

We will look to do this by amplifying these examples of work, learning from what has worked and helping to spread this across our organisations.

This strategy will provide some examples of this work in the context of our agreed areas of focus, but it should be noted that these are by no means an exhaustive or definitive list of ways in which racism is being tackled through our organisations.

Therefore, we have chosen to focus on the following areas:

Our pillars

- Workforce and leadership
- Our anti-racist approach
- Ethnic inequalities in health

The pillars within this strategy look to summarise the areas which we, as a system, feel will have the most impact on our staff and the people of North East London.

As a system we need to deliver the initiatives within these pillars, as part of wider anti-racist approach, and acknowledge the ongoing commitment needed to deliver transformational change rather than transactional activities which do not to address the issues of systemic and institutionalised racism across health and care.

Pillar One: Leadership and workforce

One of the most prominent visible examples of the impacts of historical and structural racism is within the diversity of our workforce. Our leaders are in a unique position to influence the approach and culture of organisations towards anti-racist initiatives, ensuring that all levels of our organisations work towards being anti-racist places to work.

As a system we need to review the number and distribution of staff from Black, Asian and minority Ethnic background across all levels and seniority within our organisations, ensuring that the senior roles within our organisations are as representative of our population as more junior roles.

As organisations we need to improve the quality and transparency of our approach to tackling racism and providing our workforce with greater distribution of development opportunities regardless of their race. Our leadership is key in driving this change and supporting our workforce to reduce the current barriers experienced by staff from Black, Asian or minority ethnic backgrounds.

Leadership and workforce: Pillar Commitment

As a system we are committed to being an anti-racist system which has an anti-racist approach to the way we work, and we are committed to supporting our staff and creating enabling workplaces that are reflective of the diverse population we serve.

Leadership and workforce: Pillar Summary

As a system we will ensure that the behaviours of our leaders and staff reflect our commitment to being anti-racist and ensure that, at every level, our organisations are representative of local people. North East London has a broad diversity and as such our leadership and workforce should also reflect this to showcase our commitment to the ICS and ICB as anchor institutions for our community.

As such as we need to ensure that all of our workforce has equal opportunities and is not disadvantaged through recruitment processes or through structural practices which prevent or inhibit staff from ethnic backgrounds being reflected throughout all seniorities within our organisations.

There are numerous reasons for this not being the case throughout our organisations and as such we have tried to develop three action areas which look to address the systemic causes of this and deliver a broad and impactful means of addressing the current inequalities within our leadership and workforce.

Leadership and workforce: Pillar action areas

1. Talent Programmes

As a system we will develop talent programmes for underrepresented staff groups and implement initiatives which aim to reduce the number of underrepresented groups within senior management positions within our organisations.

These talent programmes or initiatives will be focused on ensuring that staff have the support and sponsorship for roles they apply for, and we will take positive steps to remove bias and establish inclusive practices within any appointment process.

This would be to ensure that staff from Black, Asian and minority ethnic background are confident that they can have the same opportunities and access to senior roles as their white counterparts and we will see a shift in the representation of Black, Asian and minority ethnic staff into more senior grades within organisations, based on the current organisational starting positions.

Case Example

2. Board diversity

NHS organisations will ensure their board of directors' diversity by ethnicity must match closely the diversity of the workforce and population served by 2035 so that as organisations we are truly representative of our staff and our population as a whole.

This looks to put a targeted date on the requirement within the Workforce Race Equality Standard (WRES), which is a requirement for NHS commissioners and NHS healthcare providers including independent organisations.[15]

As part of the WRES, NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the small numbers of BME board members across the organisations.

[15] NHS England » NHS Workforce Race Equality Standard

This will be for individual organisations to review and decide how best to implement the required changes needed to address any underrepresented staff or populations groups within their board.

The benefits of this would be to ensure that, not only are more ethnically diverse views represented at the most senior levels within each organisation, but also that there is a visibility of staff at senior levels for the workforce and population. With our communities are clear that we have a pathway to the most senior positions for all individuals, regardless of their ethnicity.

Case Example

3. Staff training

Organisations will implement mandatory equality diversity and inclusion (EDI) or cultural sensitivity training / anti-racism training and embed anti-racism in their learning and development programmes.

The exact training needs of each organisation and its staff will be for local determination, however it is proposed that the focus of training and the outcomes of any programme, work to equip leaders, managers and staff with a range of tools, skills and knowledge to ensure our workforce becomes more culturally competent.

This may include the development of Black, Asian and minority ethnic mentoring/reverse mentoring and coaching or mandatory training for all staff around EDI, specific anti-racism, or racial bias training.

Whilst we acknowledge the limitations of mandatory training, the use of training aims to support the creation of an inclusive culture and address behaviors which are not conducive to an anti-racist workplace. It will also develop further understanding of examples and causes of systemic racism and help the understanding of concepts such as allyship and privilege, ensuring that it becomes everyone's responsibility to tack racism and not just that of Black, Asian and minority ethnic colleagues.

Case Example

Leadership and workforce: Pillar Success

If we can overcome racism within our organisations and workforce, we will be able to better represent the communities we serve, bring a broader set of lived experiences into our workplaces, and release the current talent pool of staff that are underrepresented at senior levels.

We want to ensure that all staff within organisations across North East London, feel that they have the same access to the job opportunities as their white counterparts and that the leadership of our organisations begin to accurately reflect the population of the rest of the workforce and the population we serve.

We will deliver change to ensure that we reduce the gap in the likelihood of staff from Black, Asian and minority ethnic backgrounds being shortlisted and appointed for roles when compared to white staff.

We will continue to deliver change in conjunction with our staff to ensure that views from our staff and leadership is accurately represented and is prominent in shaping the way we review and assess the impact of systemic racism on our workforce and leadership.

We will ensure that our staff, across all parts of our organisations and from all backgrounds, feel safe and confident to raise concerns within the workplace and are able to speak up against racism when they witness it and call it out without fear of reprisal.

Primarily we need to ensure our organisations are proactive and preventative when seeking to address race discrimination and systemic racism.

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Pillar Two: Our anti-racist approach

Becoming an actively anti-racist system requires us to address racism across all our activities and areas within our control and influence. The systemic racist biases that exist throughout health and care is reflected within the policies and approach to the provision of those services.

We need to identity the areas of our working practices which we can amend and that will reduce further inequalities originating from racism and actively look to address areas where we can make an impact.

By embedding anti-racist activities at the heart of our organisation's activities we can ensure that we have a significant impact on the inequalities we are witnessing within our services.

'Tackling systemic racism requires us to identify and address the drivers of this way of thinking, not just deal with the symptoms'[16]

Our anti-racist approach: Pillar Commitment

Review the processes we use to design and procure services, so they proactively support the work against racism, and ensure that our services meet our shared standards of anti-racist practices.

Our anti-racist approach: Pillar Summary

Organisations will maximise leverage against racism through their work, design, and delivery of services. As a system we need to build upon the initiatives already in place to embed anti-racist activities and attitudes across all aspects of our services and ways of working.

Anti-racism activities need to be central to all work across each organisation and North East London as a system. By amending our working practices and how we design and procure services, we will be able to address the inequal effects of our services on the population of North East London.

Our anti-racist approach: Pillar action areas

1. Service design

We want to ensure that anti-racism sentiments and anti-racist processes are embedded into service design, as this is crucial for addressing inequalities and ensuing equitable access for all people of North East London. This involves critically reviewing and examining existing services and processes to identify and eliminate systemic biases that may disadvantage certain people due to the race or ethnicity.

[16] Brap and Kline, Too hot to Handle? Why concerns about racism and not heard…or acted on, 2004

When re-designing service pathways and writing service specifications, commissioners will need to assess which ethnic groups of service users are and are not accessing services with a view of what the cause of this is, only then will we be able to identify the root causes of any inequalities.

By incorporating anti-racist principles throughout the service design lifecycle, from initial planning to implementation and ongoing monitoring and evaluation, we can work towards creating more inclusive and effective healthcare services that meet the needs of all our population.

Service Design for ART Toolkit

ART recognises that there are three key elements that encourage people to access and use our services and that the absence of these elements can create a barrier to uptake. These three elements are:

- Accessible
- Relevant
- Trusted

The aim of ART is to shift agency for accessing and using health promoting service from service users and potential service users to providers, by clarifying the drivers of uptake within their circles of control and influence. ART supports providers to identify issues and make, often small but highly effective changes which improve service uptake, retention and experience.

ART was developed as a result of the learning gained through the NHS Diabetes prevention programme assessment meetings and the community conversations around COVID-19 vaccine uptake that took place during COVID 19 vaccination campaign. It has also been informed by the Sage 2014 vaccine hesitancy framework (‘the 3 Cs’).

The ART framework provides questions to consider when reviewing a service or designing a new service from an inclusion lens in order to encourage people to access and use our services, and to avoid creating a barrier to uptake.

The ART framework has been incorporated with service design to create a comprehensive toolkit for service providers to redesign the uptake and use of services through an inclusion lens.

2. Our services

Our commitment to racial equality should extend beyond internal practices to encompass external relationships, including suppliers, contractors, and business partners. By prioritising collaborations with partners that share these values,

organisations can amplify their impact and contribute to systemic change across industries and sectors.

This approach requires organisations to systematically review and revise their policies, procedures, and practices with a racial inequalities lens, with a focus of this being to use procurement processes to ensure all services we commission support our efforts to address issues causes by racism so that potential providers have anti-racist statements and anti-racist policies.

This mean and continuous embedding of accountability to ensure key policies have race equality built into their core, so that eventually this becomes everyday business.

Case Example – Whipps cross work regarding patient skin colour

3. Ethnicity coding

There will be a focus on improving ethnicity data collection and research, and exploring ethnic identity within communities and the wider system. This includes recording ethnicity at all contacts, to ensure that we are aware of the people that we are providing services for, so that we can best design those service to meet their needs. In addition to ensuring that ethnicity is recorded at every patient contact, we will make sure that make it clear for the reasons for recoding ethnicity is explained to patients.

Providing standardisation on the sixteen ethnicity categories, allow us to more consistently collect and analysis data and have improved health monitoring and identification of inequalities amongst different ethnic groups.

Whilst we appreciate that the diversity of our population does not fit cleanly within sixteen categories and therefore there will still be issues with those who do not easily identify within these groups and whilst this will not allow us to identify inequalities to the granular level that we would ideally like to see, we acknowledge that there are national requirements and commitments for the way in which we record data.

Therefore we will work locally to see how we can supplement this national requirement with our own commitment to localising options for populations whose diversity is not accurately reflected within the national data sets.

However, we feel that setting this current baseline will enable the system to better understand our current services and the populations they serve and act as a point on which to build for future work on better understanding our population, the inequalities within services and how we can work to address them.

Case Example – TH ethnicity coding in primary care (TBC)

Our anti-racist approach: Pillar success

Establishing an actively anti-racist system across our organisations is not only an imperative to addressing some of the systemic issues that are present across our services but is also a crucial step toward making sure that as a system, anti-racist activities are at the forefront of our work.

By embedding anti-racist principles into every facet of our operations, we will position ourselves to drive meaningful change and contribute towards the reduction in inequalities across North East London.

Our commitment to working together to review our process and address any issues highlighted within the way we work will help to amplify our efforts and ensure that our organisations, and by proxy, those we ask to provide services, leads by example to help tackle some of the root causes of racial inequalities within our population.

To support this, we will commit to have anti-racist requirements and approaches to the way we work to ensure the causes of inequalities are actively addressed and reduced by organisations within the system. We will also continue to review and address any future issues as they are identified.

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Pillar three: Ethnic inequalities in health

Racism and discrimination are major drivers behind the health inequalities we still see today. It is our role as a health care system to be intentional in tackling those inequalities we see across our communities, but we should also be ensuring discrimination experienced by our staff is not further contributing to the problems.

Tackling inequalities in outcomes, experience and access is a fundamental aim for Integrated Care Systems and will form a key requirement for any strategy. The need to address racial inequalities is core requirement for an ICS as diverse as north east London, with the ambition of reducing ethnic inequalities in health ultimately being beneficial to the system and population as whole.

Ethnic inequalities in health: Pillar Commitment

Prioritise and deliver evidence informed, culturally competent interventions.

Reduce inequalities that people from ethnic minority groups face in access, experiences, and outcomes of our services.

Ethnic inequalities in health: Pillar Summary

Persistent inequalities in health outcomes represent a critical challenge for health and social services. Evidence shows that people of a Black, Asian and minority ethnic background experience higher rates of specific health conditions, poorer access to, and experience of healthcare services, and worse overall health outcomes compared to their white counterparts.

Addressing these racial inequalities is essential to addressing some of the systemic health problems, as tackling health inequalities can lead to better health outcomes not just for current population but for future generations.

Ethnic inequalities in health: Pillar action areas

1. Service inequalities

The known inequalities of access and experience in our services are a key driver in the disparity in outcomes. As part of our work to improve the outcomes in our services we will need to develop and deliver integrated and personalised care.

Current data shows us that there are inequalities in the outcomes of our services, however further work is needed to understand the inequalities in access and use of service by different groups, building on the work of our service design within the previous pillar.

Where we have identified that there are inequalities in access, experience and outcomes in services, we need to ensure that we are jointly developing services which are culturally sensitive. Using methods such as service co-location, case

management, and patient collaboration or personalised care will increase the understanding of our population needs.

We need to be honest with our communities and acknowledge that inequalities exist because of the flaws and systemic issues within our services and the design of those services and not because of the population itself.

Case Example – TH Cultural competent toolkit

2. Annual anti-racism summit

The sharing and spreading of best practice and expertise across our organisations is something which will help to foster the combined approach across the system to addressing systemic racism and the resulting health inequalities.

To support this, we will organise an annual anti-racism summit where the NEL system will be able to share best practice and examples of work which has reduced inequalities and helped to address some of the systemic issues discussed within the strategy.

This will bring all parts of the system together to discuss the steps taken to address some of the system causes of racial inequalities in our workforce and our service outcomes. The summit would also be an opportunity to review and aim to agree the steps that still need to be taken to further address racism in all forms across our organisations and services.

We also believe it is important that as a system, organisations within the ICS help to hold themselves to account for the delivery on the areas and actions outlined within this strategy.

The summit will be a key driver in the continued need to build on the momentum of individual organisational initiatives and help to continue our work towards NEL as an anti-racist system and deliver on our aim of being an anti-racist place to live and work.

3. Community engagement and insights

There is a need to review our services to identify where there is disparity in access and utilisation of services for those communities which would benefit from specific interventions. As a system we need to provide support for groups from ethnic minority communities to engage effectively in procurement and work with them within

the design process of our services to ensure they are inclusive and culturally sensitive.

We will need to ensure that we continue to collect and analyse data on patient outcomes, satisfaction, and engagement. This will help us as a system to identify areas for improvement. Data-led insights will be key to prioritise areas of work to address these insights within community groups.

Ensuring we have consistent and comparable data that we can review as organisations and as a system will help to benchmark our initiatives and support the change as we continue to meet the needs of our Black, Asian and minority ethnic communities.

The 'Big Conversation' in North East London

The 'Big Conversation' is about listening to the people in our communities, hearing their thoughts about health, care and wellbeing in North East London and, most importantly, acting on them. It focuses on what matters to local people and to work with them and our partners, to improve truly quality and outcomes and address inequalities.

The 'Big Conversation' builds on our **interim integrated care strategy** that is turning our ambitions into actions and is an opportunity to focus on what matters to local people.

The feedback we received through the **Big Conversation**, and other feedback from people across the area, showed there are five key pillars to what makes Good Care. Good Care should be:

- Accessible
- Competent
- Person centered
- Trustworthy
- Enable everyone to thrive

From Summer 2024, we have been testing these draft success measures with partners and with local people and communities. Conversations will include looking at how we could reference wider determinants of health, including quality of housing and air pollution.

Ethnic inequalities in health: Pillar success

Health inequalities are defined as 'avoidable differences in health outcomes between groups or populations.'[17] The causes of racial inequalities, are complex and

[17] Health disparities and health inequalities: applying All Our Health - GOV.UK (www.gov.uk)

interdependent, however we need to acknowledge that structural racism plays a key role in these inequalities.

Implementing initiatives which aim to address the systemic causes of these inequalities means that we look to address some of the systemic causes of racial issues within our services and the care that we provide for the people of North East London.

Not only do we need to deliver these changes in how we design and deliver these services together with our communities, but we also need to ensure that as a system we can share and spread examples of good practice across our organisations and use our collective resources to maximise the impact on improving the outcomes for our population.

The work to reduce inequalities will clearly demonstrate the commitment to reduce variations in outcomes based on race or ethnic background. Addressing inequalities can improve trust in health services amongst minority communities and act as a catalyst to further improve engagement and utilisation of services and health outcomes for all our population.

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Summary

Addressing the systemic causes and presentations of racism across our system, throughout our workforce, working practices and through the inequalities in outcomes is a strategic imperative and needs clear commitment for organisations across north east London.

These inequalities for staff and people of North East London are a result of complex interdependent factors including socioeconomic conditions, access to care, and systemic biases.

A collective and comprehensive approach towards implementing these targeted initiatives, will hopefully go some away to address some of these issues. However, where organisations have the influence and ability to do so, they should be delivered in conjunction with broader social and economic measures looking to address racial inequalities.

All system and organisational strategies and programmes should look to support the work to become actively anti-racist and ensure that they are written through an anti-racist lens and take into consideration their role in addressing racial inequalities.

This strategy aims to deliver and oversee initiatives which will ensure that, as a system, we are investing in diverse workforce and leadership development, reviewing our approach to all we do and working with and for our communities to create a more equitable health and social care across North East London.

Each pillar will have its own success measures and organisational criteria for assessing the effectiveness to help create an anti-racist system. As a system, our overarching goal is to deliver systemic change on the causes of racism across our services and the impact this has on our population.

Whilst we have chosen the three pillars detailed within this strategy, we acknowledge that we will not deliver real change unless with these actions in isolation. These initiatives need to form part of a wider system approach and commitment to address racism in all forms, wherever we encounter it.

We need to deliver on our mission to ensure that North East London ICS is an anti-racist, equitable and positive place to live and work in, and build the trust of our staff and communities, remove the apathy of our whole population towards driving systemic racial change and, through demonstrable improvements, we need to collectively empower our Black, Asian and minority ethnic communities to help us deliver the change we desire and ultimately hold us to account.

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Appendix One: NEL ICS organisational anti-racism strategies and programmes

- Active Anti-Racism: A multi-agency Charter for tackling racism, City and Hackney Safeguarding Children Partnership, 2024
- Anti-racist Principles Guidance: Working to improve fairness, justice, and equality in City and Hackney 2024, City and Hackney Neighbourhoods, 2024
- Hackney's Anti-Racism Framework, London Borough of Hackney, TBC
- Newham - Anti Racist and Equitable system development - presentation for LARCH launch event, London Borough of Newham, TBC
- Newham Health Equity Route Maps, London Borough of Newham, TBC
- Newham Health Equity Route Maps: Organisational Level, London Borough of Newham, TBC
- Newham Health Equity Route Maps: Service / Department / Team Level, London Borough of Newham, TBC
- Tower Hamlets Anti-Racist Pledge, London Borough of Tower Hamlets, TBC

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Appendix two: Reference documents

- Toward the Science and Practice of Anti-Racism: Launching a National Campaign Against Racism, Ethnicity and Disease, August 2018
- Ethnicity coding in English health service datasets, NHS Race & Health Observatory, June 2021
- Improving the recording of ethnicity in health datasets: Exploring the views of community respondents and the healthcare workforce, Race Equality Foundation and Office for National Statistics, November 2022
- Race Equality Data Metrics: As part of Anti-racism toolkit, NHSE North West Region, December 2020
- What works? Eight principles for meaningful evaluation of anti-prejudice work, Equality and Human Rights Commission, November 2017
- Annual Health Inequalities Information for NHS North East London, NEL Insights Team, July 2024
- Birmingham and Lewisham African Carribean Health Inequalities Review (BLACHIR), Birmingham City Council and London Borough of Lewisham, March 2022
- Ethnic Inequalities in Healthcare: A Rapid Evidence Review, NHS Race & Health Observatory, February 2022
- Profile of the demography of North East London, NEL Insights Team, February 2023
- Sickle cell and thalassemia prevalence in NEL, NEL Insights Team, -
- A review of how the anti-racism policies produced by London's Integrated Care Systems align with the London Anti-Racism Collaboration for Health's strategic framework: A Fuzzy-Set Qualitative Comparative Analysis and Thematic Synthesis., University College London (UCL) student, 2024

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- Developing anti-racist commissioning principles for City and Hackney, Summary of work to date, May - November 2022, Hackney Council for Voluntary Services, November 2022

- Project: MATCH Funding, VCS Enabler led system change: Testing City and Hackney anti-racist commissioning principles to tackle health inequalities, Hackney Council for Voluntary Services, March 2024

- The impact of cost of living increases on Tower Hamlets equalities groups, Tower Hamlets Council for Voluntary Services, May 2024

- The Power of Language: A Consultation Report on The Use Of Collective Terminology At The NHS Race and Health Observatory, NHS Race and Health Observatory, November 2021

- A Strategic Framework to Tackling Ethnic Health Inequalities through an Anti-Racist approach - London Anti-Racism Collaboration for Health, LARCH, July 2023

- London Anti-Racism Collaboration for Health (LARCH) - Launch Event, LARCH, November 2023

- Anti-racist Framework (Manchester framework), NHSE North West Region, TBC

- Making anti-racism a reality: East of England Race Strategy 2021, NHS England and NHS Improvement: East of England Region, 2021

- SEL ICB Staff Anti-Racism Strategy, South East London Integrated Care System, July 2023

- Advancing Mental Health Equalities: Regional programme overview, Transformation Partners in Health and Care, March 2024

- The Association of Directors of Public Health London Network: Supporting Black, Asian and Minority Ethnic communities during and beyond COVID-19, Action Plan 2021-2026, ADPH London, February 2021

- Structural Racism, Ethnicity and Health Inequalities in London, UCL Institute of Health Equity, September 2024

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