North East London Integrated Care Partnership

Wednesday 5 April 2023; 11:00-12:20; Venue MS Teams

AGENDA

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	11:00	Chair		
1.1.	Declaration of conflicts of interest			Attached	Note
1.2.	Minutes of last meeting held on 11 January 2023			Attached	Approve
1.3.	Matters arising			Verbal	Note
2.0	**Governance update**	11:05	Chair	Attached	Approve
3.0	**Joint forward plan – update**	11:15	Johanna Moss	Attached	Note
4.0	**Co-production Showcase**	11:30	Charlotte Pomery	Verbal	Note
5.0	**Questions from the public**	12:05	Chair	Verbal	
6.0	**Any other business**	12:15	Chair	-	
Date of next meeting: 6 July 2023					

North East London Integrated Care Partnership Register of Interests

- Declared Interests as at 27/03/2023

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Christopher Kennedy	Councillor	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICP Committee	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		
			Non-Financial Personal Interest	Hackney Parochial Charity	Member of Hackney Parochial Charity	2020-07-09		
			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		
Dr Paul Francis Gilluley	Chief Medical Officer	Clinical Advisory Group ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Primary care contracts sub-committee	Non-Financial Professional Interest	British Medical Association	I am a member of the organisation.	2022-07-01		
			Non-Financial Professional Interest	Royal College of Psychiatrists	Fellow of the College	2022-07-01		
			Non-Financial Professional Interest	Medical Defence Union	Member	2022-07-01		
			Non-Financial Professional Interest	General Medical Council	Member	2022-07-01		
			Non-Financial Personal Interest	Stonewall	Member	2022-07-01		
Eileen Taylor	Joint Chair, East London NHS Foundation Trust and North East London NHS Foundation Trust	ICP Committee Mental Health, Learning Disability & Autism Collaborative sub-committee	Non-Financial Professional Interest	MUFG Securities EMEA PLC	Non Executive Director	2019-04-01		
			Non-Financial Professional Interest	North East London NHS Foundation Trust	Chair from January 1, 2023	0202-01-31		
Ian Buckmaster	Member of PCCC Joint Committee	ICP Committee	Non-Financial Personal Interest	Havering Healthwatch C.I.C. (Healthwatch Havering)	Director of company	2013-04-01		

Jenny Ellis	Member of Redbridge Partnership Board	ICP Committee Redbridge ICB Sub-committee Redbridge Partnership Board	Financial Interest	Redbridge Council for Voluntary Service (Redbridge CVS)	RedbridgeCVS is a provider of social prescribing, community engagement and infrastructure support for the voluntary and community sector.	2020-01-19		
			Financial Interest	Odd Eyes Theatre Company	Trustee of a North East London-based charity that specialises in community empowerment and social inclusion through theatre.	2018-05-24		
Johanna Moss	Chief strategy and transformation officer	ICB Board ICB Population, Health & Integration Committee ICP Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee Primary Care Collaborative sub-committee Primary care contracts sub-committee	Non-Financial Professional Interest	UCL Global Business School for Health	Health Executive in Residence	2022-09-01		
John Gieve	Chair of Homerton Healthcare	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICP Committee	Indirect Interest	Pause	My wife is a trustee of Pause, the charity to support women whose children have been taken into care, and a board member of Pause Hackney.	2015-06-01		
			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		

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

Mark Santos	Redbridge Cllr & Cabinet Member Adult Services & Public Health	ICP Committee Redbridge ICB Sub-committee Redbridge Partnership Board	Financial Interest	Positive East	I am the Executive Director of the HIV Charity Positive East. Positive East receives statutory income via NEL Local Authorities & NHS via London HIV Fast Track Cities	2022-04-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Bart's Health	My sister is a Finance Manager at Barts Health	2022-04-01		Declarations to be made at the beginning of meetings
Rt Hon Jacqui Smith	Member of Integrated Care Partnership Board	ICP Committee	Financial Interest	Barking, Havering & Redbridge University Hospitals Trust	Chair in common with Barts Health NHS Trust	2021-10-01		
			Financial Interest	Sandwell Children's Trust	Chair	2021-10-01		
			Financial Interest	Jacqui Smith Advisory Limited	Director	2021-10-01		
			Financial Interest	Dalgety Limited	Non-Executive Director	2021-10-01		
			Financial Interest	Global Partners Governance	Associate	2021-10-01		
			Non-Financial Personal Interest	Jo Cox Foundation	Chair	2021-11-01		
			Non-Financial Professional Interest	Kings Fund	Trustee	2021-10-01		
			Non-Financial Personal Interest	The Precious Trust	Chair	2021-10-01		
			Non-Financial Professional Interest	UCL Partners	Director	2021-10-01		
			Non-Financial Professional Interest	Barts Charity	Trustee	2021-10-01		
Tony Wong	Chief Executive, Hackney Council for Voluntary Services	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICP Committee	Non-Financial Professional Interest	Hackney Council for Voluntary Services	Chief Executive for Hackney Council for Voluntary Services	2021-10-04		Declarations to be made at the beginning of meetings
Zina Etheridge	Chief Executive Officer Designate of the Integrated Care Board for north east London	ICB Audit and Risk Committee ICB Board ICB Population, Health & Integration Committee ICB Workforce & Remuneration Committee ICP Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee	Indirect Interest	Royal Berkshire NHS Foundation Trust	Brother is employed as Head of Acute Medicine at Royal Berkshire hospital	2022-03-17		Declarations to be made at the beginning of meetings

- Nil Interests Declared as of 27/03/2023

Name	Position/Relationship with ICB	Committees	Declared Interest
Dianne Barham	Healthwatch, Tower Hamlets	ICP Committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Charlotte Pomery	Chief Participation and Place Officer	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Havering ICB Sub-committee Havering Partnership Board ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Maureen Worby	Councillor In London Borough of Barking & Dagenham	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee	Indicated No Conflicts To Declare.
Cathy Turland	Member of a committee	ICP Committee Redbridge ICB Sub-committee Redbridge Partnership Board	Indicated No Conflicts To Declare.
Paul Rose	Chair of the Havering Compact	Havering Partnership Board ICP Committee	Indicated No Conflicts To Declare.
Matthew Adrien	Partnership working	ICP Committee Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Indicated No Conflicts To Declare.
Caroline Rouse	Member of IC Board (VCS rep)	ICB Board ICP Committee	Indicated No Conflicts To Declare.
Gillian Ford	Councillor, member of a joint committee	Havering Partnership Board ICP Committee	Indicated No Conflicts To Declare.
Veronica Awuzudike	Healthwatch Newham Manager	ICP Committee Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Catherine Perez Phillips	Committee member	ICP Committee	Indicated No Conflicts To Declare.
Naheed Asghar	Committee member	ICP Committee Waltham Forest Health and Care Partnership Board	Indicated No Conflicts To Declare.
Gulam Kibria Choudhury	Member	ICP Committee	Indicated No Conflicts To Declare.

DRAFT

Minutes of the North East London Integrated Care Partnership

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

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

Item No.	Item title	Action
1.0	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the first formal meeting of the Integrated Care Partnership (ICP) held virtually in public. The Chair also welcomed members of the public who had joined the meeting to observe.	
1.1.	**Declaration of conflicts of interest**	
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the ICB. No additional conflicts were declared. Declarations declared by members of the ICP are listed on the Register of Interests. The Register is available from either the Governance Team or on the ICB's website (northeastlondonicb.nhs.uk)	
1.2.	**Minutes of last meeting**	
	The minutes of the meeting held on 23 November 2022 were agreed as a correct record.	
1.3.	**Matters arising**	
	There were no matters arising from the previous meeting.	
2.0	**Approval of the interim Integrated care strategy**	
	The strategy presented is an interim document as there are plans for a 'big conversation' in the Spring with local people and communities to inform the content of this strategy and the joint forward plan, with an emphasis on measures and what success looks like. Feedback from this meeting will be incorporated into the next version will be published pending publication of further guidance from the Department of Health and Social Care expected in June 2023 There has been widespread engagement across the system including with place-based partnerships and health and wellbeing boards. All participation and contributions made from across the system has been gratefully received and recorded and members thanked for their involvement and agreed that it has been a very collaborative system wide process and sets a firm foundation for the partnership going forward. Members were asked to focus on any important areas missing from priorities and cross cutting themes and does it have the right level of ambition and scope for success measures. Comments received included: • Members could take this back to places and health and wellbeing boards to look at what additional actions will need to be done locally that will complement and help deliver the strategy. • The next meeting can discuss what information the ICP will need as a partnership to ensure it is moving forward on the priorities. • Workforce should be emphasised in the introduction and how it underpins the ability to fulfil all of the system priorities.	

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	• Acronyms should be removed or made clear. • Page numbers in the strategy to be added. • The reference to social prescribing should be made clearer that it includes all people and not just children and young people. • Smart objectives will be developed and brought back to a future meeting. • Case studies could be provided on models and exemplars and a separate piece of work could be undertaken to provide this. • There is little reference to quality, and this should be emphasised. • Success measures align well with the trusts in the system and that they will be able to add to these going forward. • The next iteration can include more focus on functions that are working and that should be maintained and improved upon. • To acknowledge that significant changes in how people work can change with immediate pressures. This can be referred to in the introduction but can be in more detail in the Joint Forward Plan. • Places are focusing on primary prevention but also secondary and tertiary prevention and this should be made clear within the text. • Importance of social care expanded throughout especially for long term conditions. • Cost of living is important but also references to poverty should be included. • To clarify if the reference under population should say minority ethnic rather than mixed ethnicity. • Include the agreed ICS Design Principles as agreed by the wider partnership to be included in the section on high trust environment. • Reference the need for equity with all partners eg co-production and a high trust environment • To reach and engage marginalised communities, acknowledge that the voluntary and community sector (VCS) is key, and therefore equity about how the VCS is factored in will need to consider resource allocation to help to deliver the strategy. Next steps agreed: • To look at how it will be part of all joint partners plans and feeding back • Success should include integration and is defined by local people • Comments will be reviewed and incorporated into a final interim strategy for publishing on the website. The Integrated Care Partnership agreed the final draft of the Integrated care Strategy subject to inclusion of comments and changes suggested. The final interim strategy will be presented to the ICB Board on 25 January and will be published on the ICB and partnership website.	HR/JM
3.0	**Joint forward plan – an introduction**	
	The Health & Care Act 2022 requires each ICB in England, and their partner NHS trusts and foundation trusts, to produce and publish a Joint Forward Plan (JFP). The JFP is expected to be a delivery plan for the integrated care strategy of the ICP and relevant joint local health and wellbeing strategies, whilst addressing universal NHS commitments. A final draft of	

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	the JFP is to be submitted by end of March and then a final draft to be published by 30 June 2023. There are three different component parts that it must include: Universal NHS requirements, core purpose and legal requirements. Close engagement with system partners is essential and engagement work undertaken for the strategy can be built upon. Comments included: • It is NHS focussed but there are elements that local authorities can have valuable input such as with climate change. • There is no reference to the voluntary and third sector. • This is the plan that will shape NHS resources and it was acknowledged that the development of the plan is currently more NHS focussed but later iterations will incorporate all system partners and this can be used to underpin the next steps and will reflect wider partners. • There are already good examples of integration work and co-production that should be highlighted. • Organisations should move away from separation of partners and just move to integrated partners • Local authorities will be represented on the JFP development group. • The ICP steering group is continuing and the terms of reference will be presented at the next meeting for approval. The steering group will also review the JFP as it develops. • The JFP can also be discussed and drafts shared through established forums such as the meeting of Local Authority leaders, HealthWatch and Voluntary sector group meetings. • This is a five year plan but the focus will be on the first year which will be updated annually. An operating plan is also being developed which will have detailed numbers which will be used to reference in the JFP. The Integrated Care Partnership noted the update on the development of the Joint Forward Plan. Comments will be noted and fed back into the draft.	
4.0	**Questions from the public**	
	None received	
5.0	**Any other business**	
	It was agreed that current pressures should be highlighted at this meeting. This will include all partners and cover areas such as critical pressures in the NHS and demand or local government budgets and community issues. This can be an item at the next meeting.	KC
	Date of Next meeting – 5 April 2023	

Integrated Care Partnership Actions Log

OPEN ACTIONS

Action ref:	Date of meeting	Item no	Action required	Lead	When	Status
ACT001	23/11/22	5.0	**Integrated care strategy next steps** All input from conversations and engagement undertaken and detail from the slide decks will be converted into the first iteration of the strategy which will be shared with partners prior to Christmas for comment. The interim strategy will then be presented to the integrated care partnership meeting scheduled on 11 January 2023 for agreement	JM/HR	Jan 2023	On the agenda and actions completed
ACT002	11/01/23	2.0	**Integrated care strategy** Comments received will be incorporated as appropriate into the final interim strategy for publishing on the website.	HR/JM	Jan 2023	Completed
ACT003	11/01/23	5.0	**System pressures** Current system pressures to be highlighted at meetings.	KC	Mar 2023	On the forward plan

Integrated Care Partnership Committee

5 April 2023

Title of report	Governance Update
Author	Marie Price, Director of Communication and Involvement
Presented by	Marie Gabriel, Chair, NHS North East London and North East London Health and Care Partnership
Contact for further information	Marie.price9@nhs.net
Executive summary	The Integrated Care Partnership (ICP) Committee is now formally established as a key element of the North East London Health and Care Partnership governance, operating as a joint committee of the Integrated Care Board (ICB) and all eight local authorities, with broad and inclusive membership across all partners in our system. The terms of reference for this Committee were agreed at the last meeting. Last year following extensive partnership discussions and workshops, it was agreed to establish a 'steering group' for the ICP given the size of the Committee. The steering group began to meet in September to steer and plan the work of the wider ICP, including the wider terms of reference, agenda, ICP strategy and more recently the joint forward plans. It provides a pragmatic way to ensure a smaller group can focus on the detail and plan for what is a large committee given the size of our ICS. The group includes members from across the constituent partners and is working well. Given the ICP Committee is the formal statutory committee of the local authorities and ICB, we need to now formally approve the establishment and terms of reference for the steering group given its relationship to this Committee. **The terms of reference have been agreed by the steering group and are attached for approval.** The steering group agreed that a deputy chair should be established and Councillor Neil Wilson of the London Borough of Newham will take on the role. Because this Committee is joint with local authorities, the steering group recommended that Councillor Wilson also take on the role of deputy chair to the overall ICP Committee. This was discussed at a meeting of the local authority cabinet members/leaders and relevant executives on 27 March, who endorsed the proposal. **Members of this committee are asked to agree that Councillor Wilson become Deputy Chair to the ICP Chair, Marie Gabriel.**

	The steering group has also been discussing the forward plan for formal and development sessions of this Committee. It was proposed that agendas should ensure a discussion on the progress of the four flagship priorities in the public part of the meeting, followed by a deep dive into one of our cross-cutting themes, as these themes define how we would work together as a partnership. The group also proposed that the July meeting be in person, to further build relationships. **The draft plan is attached for discussion and comment.**
Action required	**To agree:** • To formally establish and approve the terms of reference for this Committee's steering group. • That Councillor Wilson become Deputy Chair of this Committee. **To discuss and comment:** • On the draft forward plan and approach to future meetings.
Previous reporting	• Discussed at the ICP's steering group
Next steps/ onward reporting	• Partners to update as appropriate
Conflicts of interest	N/A
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	This Committee and its steering group are focussed on supporting the wider partnership committee to deliver on our commitments for local people as set out in the ICP strategy.
Impact on finance, performance and quality	Planning ahead for partnership discussions and review on our strategy, aims and objectives will ensure we are focussed together on delivering improvements, including finance, performance and quality.
Risks	To mitigate any risk that the partnership is not driving improvement and making an impact where it matters most for local people, a strong steering group with a collectively agreed forward plan will ensure that our focus is where it needs to be.

North East London Integrated Care Partnership Steering Group

TERMS OF REFERENCE

Status	1. The North East London Integrated Care Board ([1]the '**ICB**') and the eight local authorities in the ICB's area, have come together with other system partners to establish the North East London Integrated Care Partnership ('**ICP**'). The ICP is a core component of the North East London Health and Care Partnership, which is the Integrated Care System ('**ICS**') for the area. 2. These terms of reference are for the North East London Integrated Care Partnership Steering Group ('**the Steering Group'**), which has been established by the ICP, to guide and support its work.
Purpose and responsibilities	3. Given the size and scale of the ICP, which is an inclusive group of health and care partner organisations from across the ICS, the Steering Group has been established to steer the work and strategic direction of the wider Partnership. 4. The Steering Group will support the ICP to fulfil its responsibilities as set out in it terms of reference and, more broadly, in legislation and guidance published by the Secretary of State. 5. The Steering Group will focus on the approach to development and oversight of the Integrated Care Strategy, with due regard to the ICP's responsibilities in that regard. Once the strategy is published, the Steering Group will continue to support the ICP and the statutory partners with its implementation, providing advice and guidance as appropriate. 6. The Steering Group will act as a programme board. It has no formal decision-making powers of its own, but may make recommendations to the ICP to inform its decisions. 7. The Steering Group will inform the development and review of the ICP Chair's objectives.
Chairing arrangements	8. The Steering Group will be Chaired by the Chair of the ICB, who is also the Chair of the ICP. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

[1] The ICB is the statutory system-wide NHS body responsible for planning and funding most NHS services in the area. The ICP is a statutory committee that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop a health and care strategy for the area. (source: Kings Fund)

	9. The Steering Group may appoint a Deputy Chair from amongst its members.
Membership	10. The membership of the Steering Group, which has been agreed by the ICP, shall be 9, as follows: (a) Chair of the ICB (Chair) (b) One local authority elected member from 'inner' North East London (c) One local authority elected member from 'outer' North East London (d) One NHS Trust/Foundation Trust Chair (acute sector) (e) One NHS Trust/Foundation Trust Chair (mental health/community health sector) (f) Chief Executive of the ICB (g) One individual nominated by [the North East London VCSE Collaborative] (h) One individual nominated by [by North East London Healthwatch group] (i) One individual nominated by [the North East London Primary Care Collaborative] 11. Attendance at meetings is essential. In exceptional circumstances when a member cannot attend, subject to the Chair's consent they may arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. 12. Members of this group will connect with and bring the perspective of their wider sector collaborative groups.
Participants	13. Only members of the Steering Group have the right to attend meetings. However, other individuals may be invited to attend all or part of any meeting as and when appropriate to assist the Steering Group with its discussions. 14. The following shall attend in a non-voting capacity, in order to provide strategic advice to the Steering Group: (a) A Director of Public Health drawn from one of the eight local authorities in North East London. (b) Others, as required, including: Directors of Adult Social Care, Directors of Children's Services, Local Authority Chief Executives, ICB Chief Officers (e.g. medical, strategy and place/participation). 15. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Meetings, Quoracy and Decisions	*Scheduling meetings* 16. The Steering Group will normally meet in advance of each meeting of the ICP, which will ordinarily be quarterly. Additional meetings may be convened at the discretion of the Chair. *Quoracy* 17. For a meeting to be quorate, five of the members must be present. This must include at least one ICB member, one local authority member and one trust/FT member. *Voting* 18. The Steering Group will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the Steering Group may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair will hold the casting vote. The result of the vote will be recorded in the minutes. *Papers and notice* 19. A minimum of seven clear working days' notice is required of the date and time of a meeting. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting 20. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair. *Virtual attendance* 21. It is for the Chair to decide whether or not the Steering Group will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes. *Recordings of meetings and publication* 22. Except with the permission of the Chair, no person admitted to a meeting of the Steering Group shall be permitted to record the proceedings in any manner whatsoever, other than in writing. *Confidential information* 23. Where confidential information is presented to the Steering Group, all those who are present will ensure that they treat that information appropriately in

	light of any confidentiality requirements and information governance principles. *Meeting minutes* 24. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the Steering Group together with the action log as soon after the meeting as practicable. The minutes will be submitted for agreement at the next meeting where they will be signed by the Chair. *Governance support* 25. Governance support to the Steering Group will be provided by the ICB's governance team. *Conflicts of interest* 26. The Steering Group is committed to conducting its business in a fair, transparent, accountable and impartial manner. Members will comply with the arrangements for managing conflicts of interest established by the organisations that they represent or the ICS as a whole, and any relevant national statutory guidance.
Behaviours and Conduct	27. All members shall follow the Seven Principles of Public Life (i.e. the Nolan Principles), which are: selflessness, integrity, objectivity, accountability, openness, honesty and leadership. 28. Members of the Steering Group have a collective responsibility for its operation. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view and reach agreement by consensus. The purpose of the Steering Group is to consider the best interests of service users and residents in North East London, when taken as a health and care system as a whole, rather than representing the individual interests of any of the partner organisations over those of another. Steering Group members participate in the Steering Group to - as far as possible - promote the greater collective endeavour. 29. Members must demonstrably consider equality, diversity and inclusion implications of the recommendations they make.
Accountability and Reporting	30. The Steering Group shall comply with any reporting requirements that are specifically required by the ICP, or any of the statutory partner organisations for the purposes of its constitutional or other internal governance arrangements. 31. Members of the Steering Group shall disseminate information back to their respective organisations as appropriate, and feedback to the group as needed.
Review	32. The Steering Group will review its effectiveness at least annually.

	33. These ToR will be reviewed at least annually and more frequently if required. Any proposed changes to these terms of reference will be agreed by the ICP.

Date of Approval: [ ]
Date of Review: [ ]
Version: [1.0]

Integrated Care Partnership

DRAFT - Forward plan 2023/24

Month	Item	Lead
Standing items	• Apologies • Declarations of interest • Minutes of the last meeting • Matters arising • AOB	Chair
Wednesday **5 April 2023**	• Draft Joint Forward Plan • Cross cutting theme – deep dive: co-production • Governance update	JM MP
Thursday **6 July 2023**	In person meeting • System priorities update • Review/reflection on the past year • Agreement on success measures • External/keynote speaker relating to one of our system priorities	 ZE MG MG MG
Wednesday **4 October 2023**	• Joint Forward Plan / Operating Plan • System priorities update • Cross cutting theme – deep dive: TBA	JM ZE TBA
Wednesday **10 January 2024**	• System priorities update • Cross cutting theme – deep dive: TBA	ZE TBA

Integrated Care Partnership

5 April 2023

Title of report	Joint Forward Plan – March submission
Author	Johanna Moss, Chief Strategy and Transformation Officer
Presented by	Johanna Moss
Contact for further information	johanna.moss1@nhs.net
Executive summary	Attached is a complete draft of our system's Joint Forward Plan (JFP) – a five-year plan describing how we will, as a system, deliver our Integrated Care Partnership Strategy as well as core NHS services – and a supporting reference document providing further detail on the transformation programmes described in the main plan. We need to submit a draft of the plan to NHSE by the end of March, before further work and engagement across the system during April and May so that we can publish in June 2023. The plan will then be refreshed on an annual basis.
Action / recommendation	The Integrated Care Partnership is asked to provide comments on the plan so that these can be incorporated into the April-June process.
Previous reporting	The Strategy Task and Finish Group is leading the development of the plan. Versions of the plan have also been discussed at the ICP Steering Group, NEL Chief Executive Officers' group and at the NEL Executive Management Team. This version was sent to the NHS NEL ICB Board for final comments and sign-off on 29th March. (Feedback from these groups will be incorporated into the submission to NHSE but may not be reflected in the attached version).
Next steps/ onward reporting	During April-June engagement with system partners will take place, iterating the plan further, aligning programmes and identifying re-prioritisation required to support achievement
Conflicts of interest	None identified.
Strategic fit	The JFP covers all of our ICS aims: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development

Impact on local people, health inequalities and sustainability	The JFP represents (at this stage) a consolidation of existing plans, rather than new plans. Any reprioritisation will be on the basis of engagement during April-June. An equalities impact assessment has not been undertaken at this stage.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report. The JFP represents (at this stage) a consolidation of existing plans, rather than new plans. Any reprioritisation will be on the basis of engagement during April-June.
Risks	Nationally dictated timescales mean that less engagement with system partners has been possible in the plan's development than would be ideal. The development team will endeavour mitigate this through a strong engagement plan for the next phase of work.

North East London Health & Care Partnership

NHS North East London

DRAFT

North East London (NEL) Joint Forward Plan

March 2023

1. Introduction

Introduction

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

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

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

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

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

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

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

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

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

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

Critically we are committed to a relentless focus on equity as a system, embedding it in all that we do.
Both the strategy and this Joint Forward Plan build upon the principles that we have agreed as London ICBs with the Mayor of London

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

Improve quality & outcomes	Deepen collaboration	Create value	Secure greater equity

6 Crosscutting Themes underpinning our new ICS approach

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

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

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

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

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

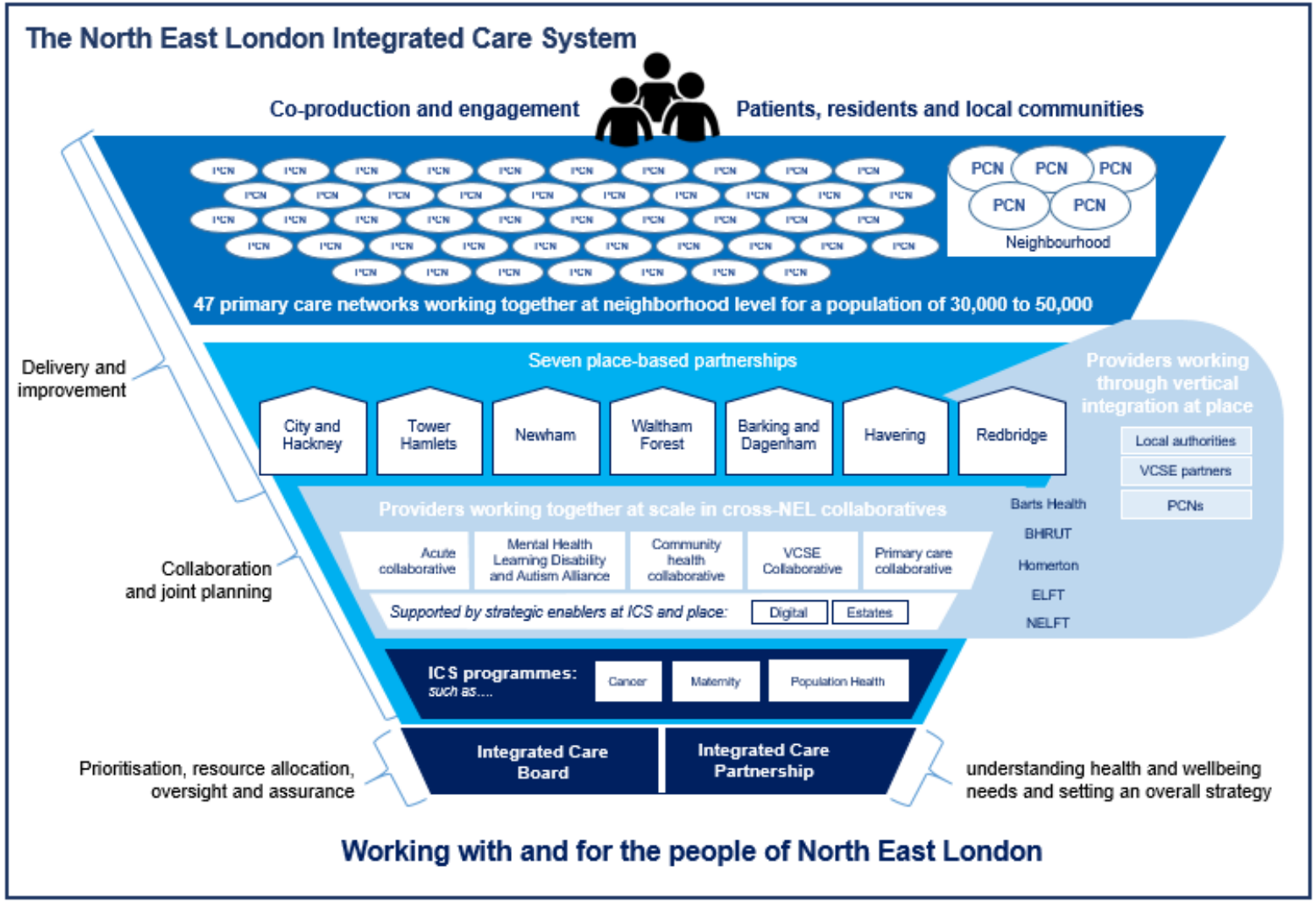
We are a broad partnership, brought together by a single purpose: to improve health and wellbeing outcomes for the people of north east London.

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

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

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

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



2. Our unique population

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

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

Rich diversity

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

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

Young, densely populated and growing rapidly

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

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

Poverty, deprivation and the wider determinants of health

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

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

Stark health inequalities

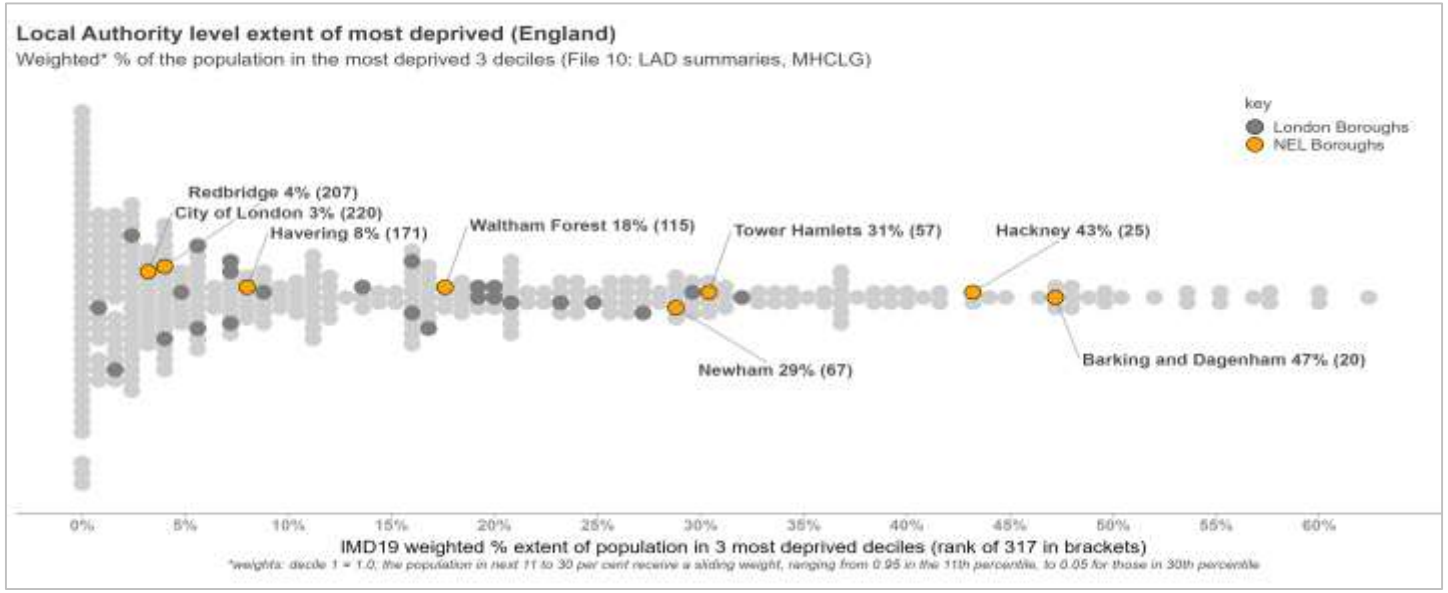
There are significant inequalities within and between our communities in NEL, and our population has worse health outcomes than the rest of the country across many key indicators. Health inequalities are linked to wider social and economic inequalities including poverty and ethnicity.

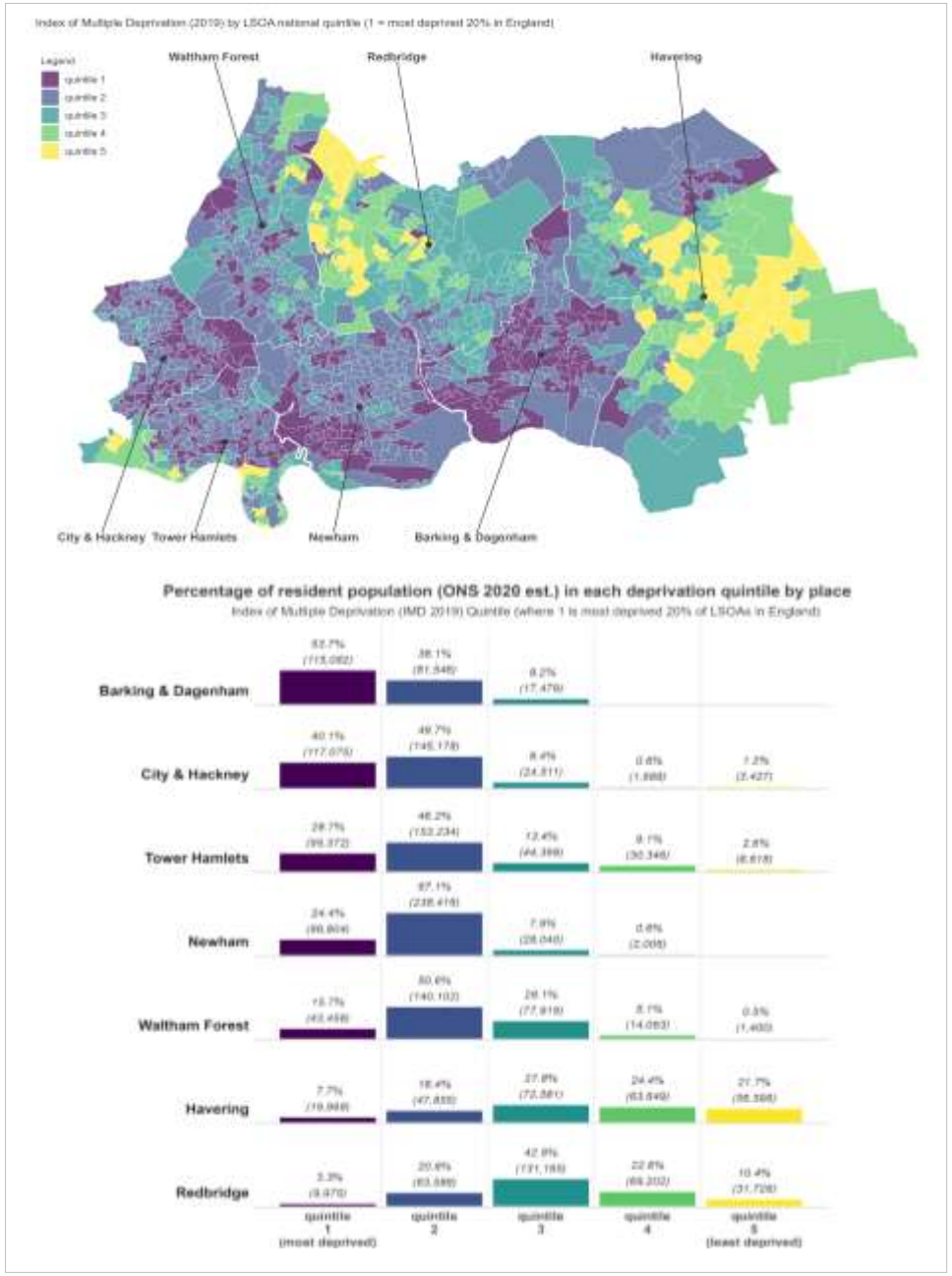
Our population has been disproportionately impacted by the pandemic and recent cost of living increase.

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

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

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





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

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

Child Obesity

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

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

Mental Health

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

Tobacco

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

Premature CVD mortality

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

Vulnerable housing

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

Homelessness

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

Childhood Poverty

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

Childhood Vaccinations

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

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

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

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

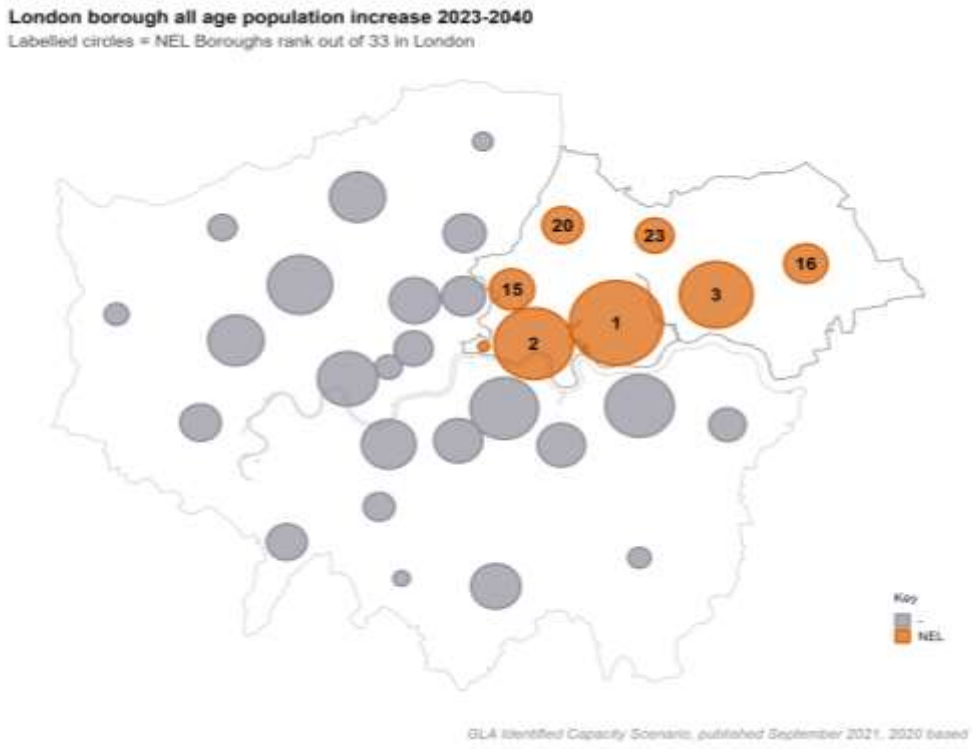
Our population is not static – we expect it to grow by over 300,000 in the coming years, significantly increasing demand for local health and care services

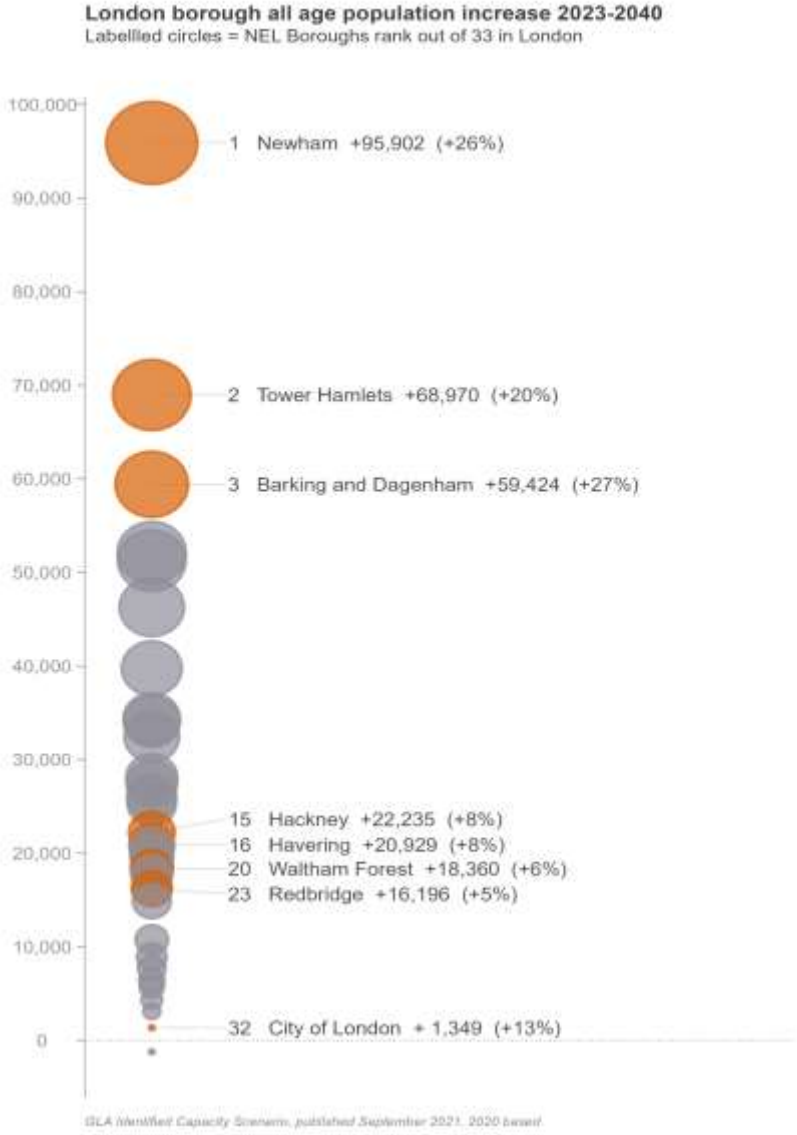
The population of north east London (currently just over 2 million) is projected to increase by almost 15% (or 300k people) between 2023 and 2040, the equivalent to adding a whole new borough to the ICS, and by far the largest population increase in London.

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

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

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

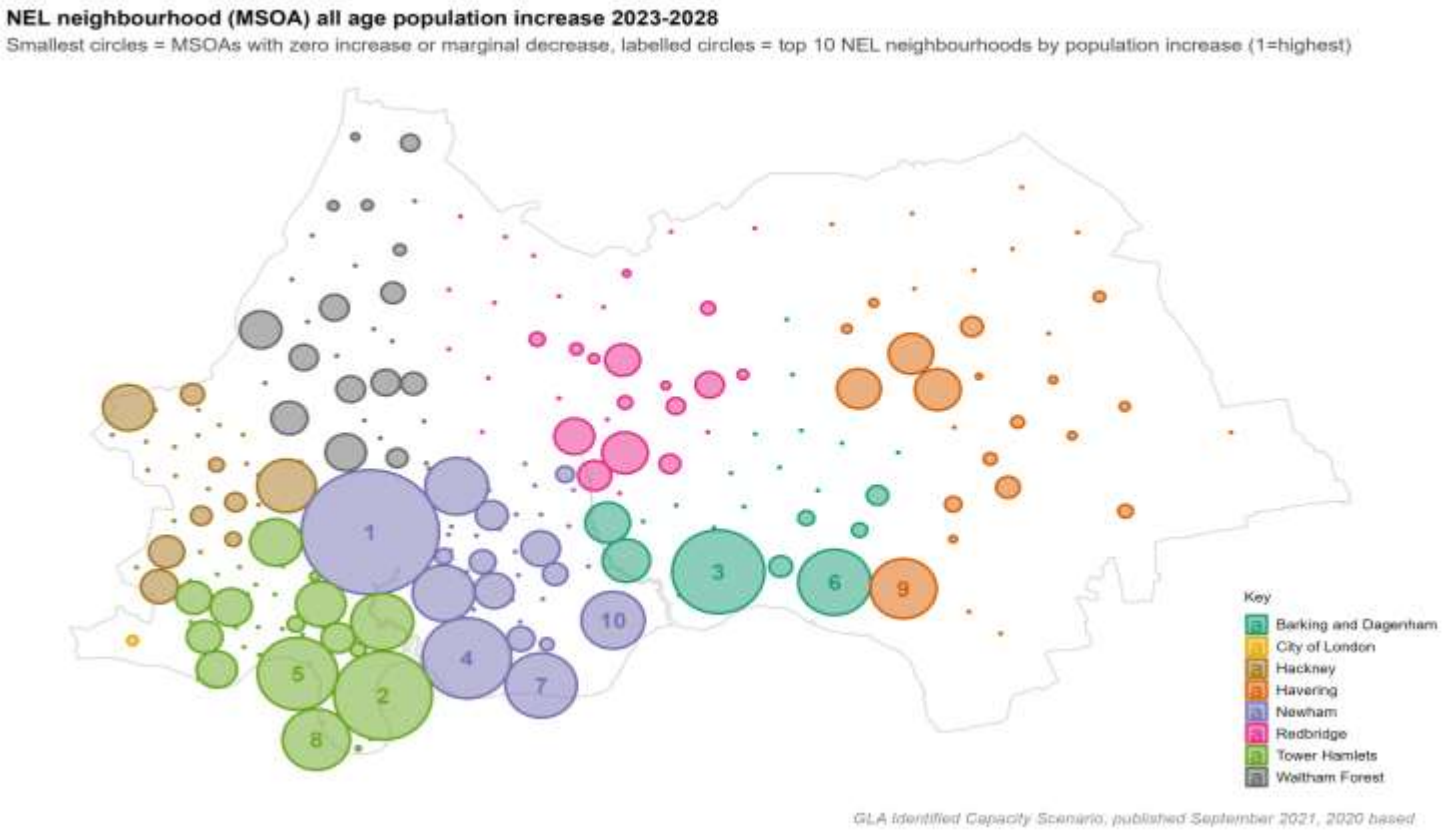


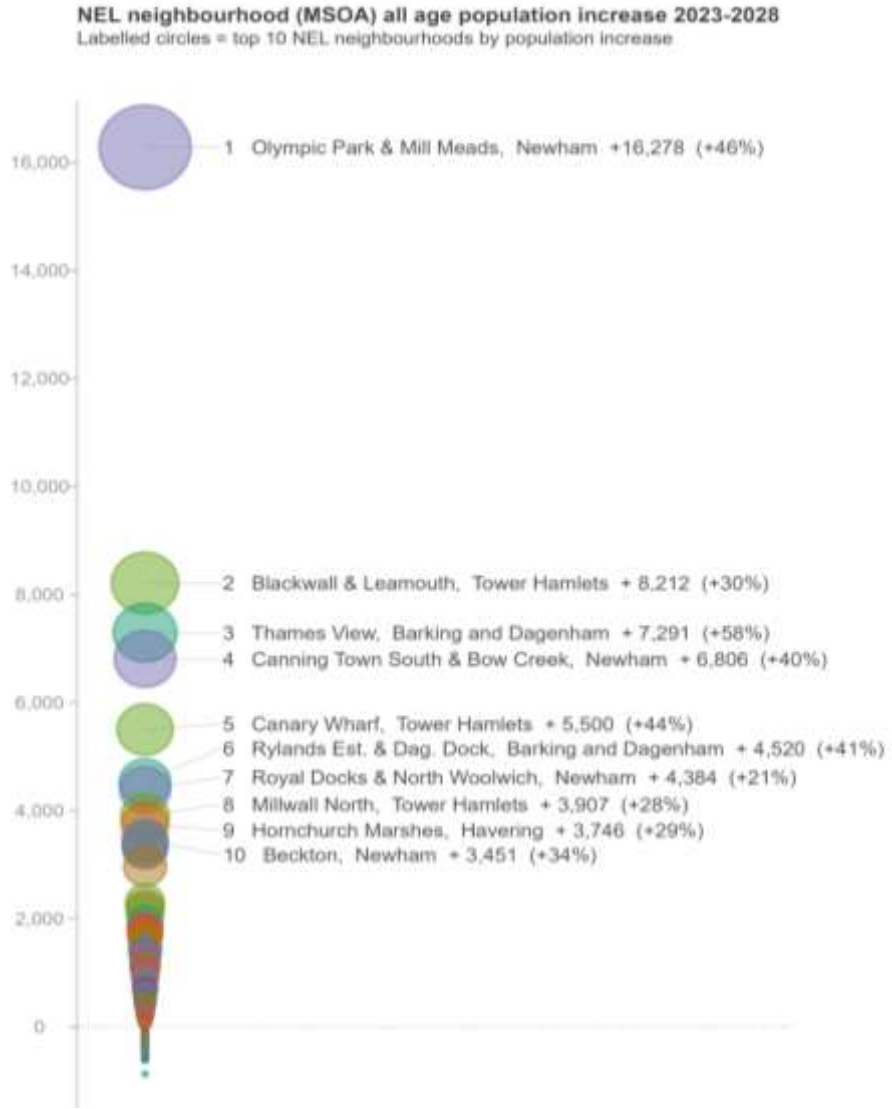


We need to act urgently to improve population health and address the impact of population growth

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

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





3. Our assets

We have significant assets to draw from

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

Our assets

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

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

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

- **Financial resources** – we spend nearly £4bn on health services in NEL, and across our public sector partners in north east London, including local authorities, schools and the police, there are around £3bn more. By thinking about how we use these resources together, in ways which most effectively support the objectives we want to achieve at all levels of the system, we can ensure they are spent more effectively and in particular in ways with improve outcomes and reduce inequality in sustainable way.

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

Our health and care workforce is our greatest asset

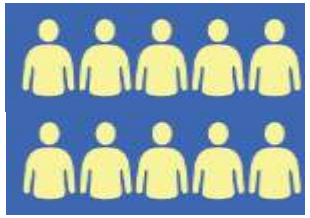
To be updated during April-June in line with People Strategy currently under development

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

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

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

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



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

Our workforce includes -

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

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

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

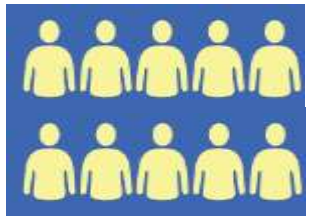
In NEL we are supporting the development of a VCSE Collaborative to create the enabling infrastructure and support sustainability of our rich and diverse VCSE in NEL, also ensuring that the contribution of the VCSE is valued equally.

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

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

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

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



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

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

4. Our challenges and opportunities

The key challenges facing our health and care services

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

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

The wider determinants of health are also key challenges that contribute to challenges, across most of our places we have seen unemployment rise during the pandemic, although this number is dropping, we still have populations who are still unemployed or inactive.

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

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

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

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

We face substantial pressures on same day urgent care

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

We have a large backlog of people waiting for planned care

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

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

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

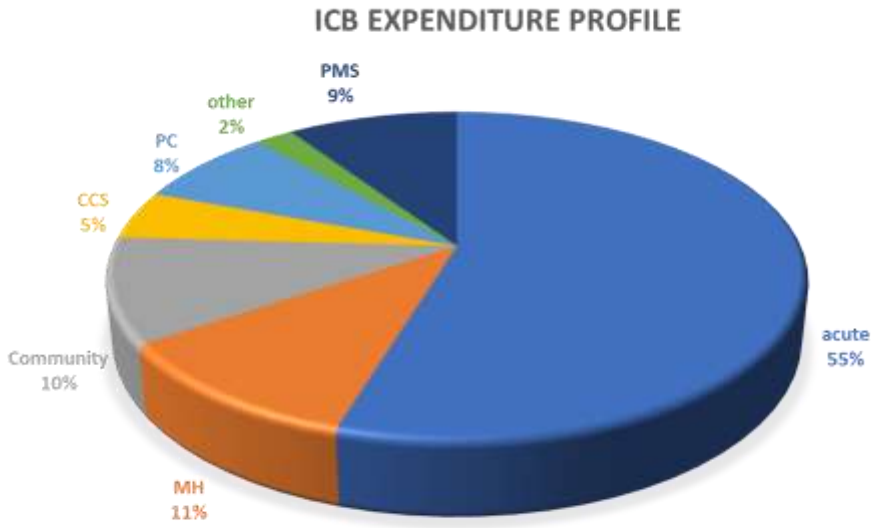
- North east London currently has relatively few GP appointments per 100,000 weighted population (39,244 vs a median for all ICSs of 42,360 – i.e. the national median is around 8% greater than in NEL), suggesting part of the cause of pressure on other parts of the system, including greater than expected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

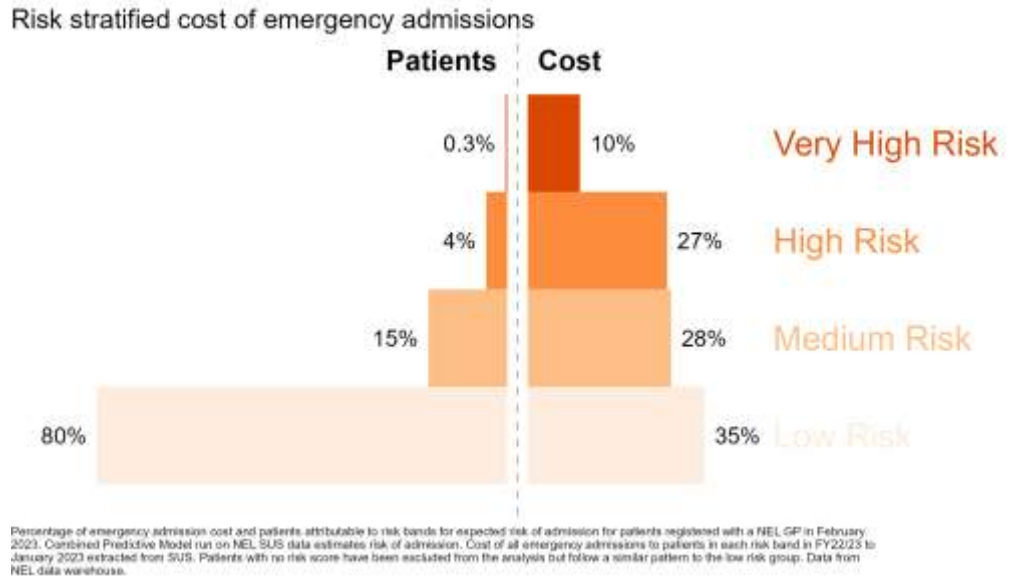
Long term conditions

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

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

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





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

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

5. How we are transforming the way we work

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

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

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

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

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

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

2. Our NEL strategic priorities

3. Our supporting infrastructure

4. Local priorities within NEL

A quick snapshot of NEL's transformation work

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

By April 2024

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

Urgent and emergency care

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

Over the next two years

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

Over years three to five

- Further development of virtual consultations for U&EC

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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

Community health services

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Primary care

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Planned care and diagnostics

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

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

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

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

Key programme features and milestones:

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

Key milestones include:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Cancer

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

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

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

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

Key programme features and milestones:

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

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Maternity

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Babies, children, and young people

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

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

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

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

Key programme features and milestones:

- Improved SEND provision focuses on: leading SEND, early identification and assessment, commissioning effective services, good quality education provision & supporting successful transitions.
- Tackling childhood obesity has 3 focus areas: healthy places, healthy settings, healthy services.
- More integrated services plans to start with the ambition of creating an effective Early Help Eco system with a common practice approach
- Levelling up H@H ensuring equality of access and services
- Build upon and increase existing community capacity, aligning to family hubs and strengthening adolescent healthcare. Through social prescribing and multi-disciplinary teams we will enable links to community assets including the community and voluntary sector and put health inequalities at the heart of our work
- Developing integrated care models and pathways for children across primary secondary and community care
- Give patients and (with patient consent) carers and clinicians involved in their care, better access to their care record

Further transformation to be planned in this area:

Over the next two years to five years

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Long-term conditions

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

April 2024:

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

April 2026:

- Improve detection of **atrial fibrillation (b**y 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation) AND **hypertension** (by 2029 80% of expected numbers with hypertension are detected and 80% of people with high blood pressure are treated to target)
- Robust transition pathways for children living with diabetes across NEL
- Maximise patient dialysing at home AND patients being transplanted
- Pulmonary Rehab available to patients with all chronic lung conditions and all local languages

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

- By taking a population health approach and using insights and data to inform priorities, target inequalities and variation
- By utilising deep dive data analysis into local participation rates to support target local campaigns to improve equitable access to diabetes treatment by sex
- By reducing unwarranted variation in access to specialist assessment and treatment for Neurosciences within 24 hours of symptom onset for NEL residents with TIA which currently ranges between 40% for BHR residents to 92% for City and Hackney residents
- By April 2024 all Places will have accredited providers (Hublets) of Diagnostic Spirometry and FeNO to reduce inequalities across NEL (currently available in 3 Places with none-to-little provision in remaining 4 Places) to be followed by educational videos in all local languages to explain the why & how of respiratory diagnostic testing.

Key programme features and milestones:

- Roll out of the LTC outcomes framework (Q2 23/24) (led contractually by primary care) – impacting on benefits
- Co-produce 7 day TIA service with residents so that 90% of people with TIA
- New Digital PR DHI with shared-working between places (co-production start. March 2023 with potential capacity for c.250 extra participants a year).
- Acute Respiratory Infection (ARI) Virtual Wards (with plan for provision in each Place before Winter 23/24).

Further transformation to be planned in this area:

Over the next two years

- Improve acute stroke standards and flow across the stroke pathway

Over years three to five

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Mental health

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

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

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

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

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

Further transformation to be planned in this area:

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

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

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

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

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

Alignment to the integrated care strategy:

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

Employment and workforce

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Physical infrastructure

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Digital infrastructure

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Further programmes

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

Led by	Programme	Page*
Acute provider collaborative	Critical care	85
	Research and clinical trials	86
	Specialist services	87
Mental health, learning disabilities, and autism collaborative	Lived experience leadership programme	88
	Learning disabilities and autism improvement programme	89
Barking and Dagenham place partnership	Ageing well	90
	Healthier weight	91
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City and Hackney place partnership	Supporting with the cost of living	94
	Population health	95
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Havering place partnership	Infrastructure and enablers	97
	Building community resilience	98
	St George's health and wellbeing hub	99
	Living well	100
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Newham	Frailty model	102
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Newham place partnership	Learning disabilities and autism	105
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	Discharge pathways programme	123
	Pharmacy and Medicine Optimisation/ NEL	124

6. Implications and next steps

Early lessons from work to develop this plan

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

Analysing our transformation portfolio - i

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

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

Analysing our transformation portfolio - ii

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

Analysing our transformation portfolio - iii

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

Next steps

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

Technical work

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

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

Engagement

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

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

7. National planning requirements lookup tables

Links to other plans and strategies

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

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

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

Annex 8. Engagement plan

How we engage with our partners on the Joint Forward Plan

- We have involved an extensive range of people in the development of our Joint Forward Plan and have been guided by our ICS Strategy Task & Finish Group to ensure partnership co-design.
- We now embark on a wider engagement with all our partners across the health and care landscape in north east London. This will involve all our Place-based Partnerships, our Provider Collaboratives and the Health and Well-being Boards. Furthermore, we will also engage with other key stakeholders such as our voluntary and community sector, our care providers as well as local residents through our Big Conversation. This will then be approved through the formal governance within our ICS: the ICP Steering Group, the ICB Board and the ICP Full Meeting.
- Part of the conversation will be focussed on this year's Joint Forward Plan to ensure it represent our whole system plan. In addition, we want to explore how we learn from this year's process to enable our joint planning to evolve over the year and informs how we develop the next year's Joint Forward Plan. This will be the start of a continuous dialogue and process across our partnership towards operating fully as a learning system.
- A high-level timeline has been included below.

- ICS Strategy T&F Group
- ICP Steering Group
- ICB Board
- EMT
- Exec Committee to the ICB Board
- ICP Full Meeting

- Place-based Partnerships x 7
- Health and Well-being Boards x 8
- Voluntary and community sector engagement
- Care providers engagement
- Big Conversation with the local residents

- ICS Strategy T&F Group
- ICP Steering Group
- ICB Board
- EMT
- Exec Committee to the ICB Board
- ICP Full Meeting

Annex 9A - demand projections

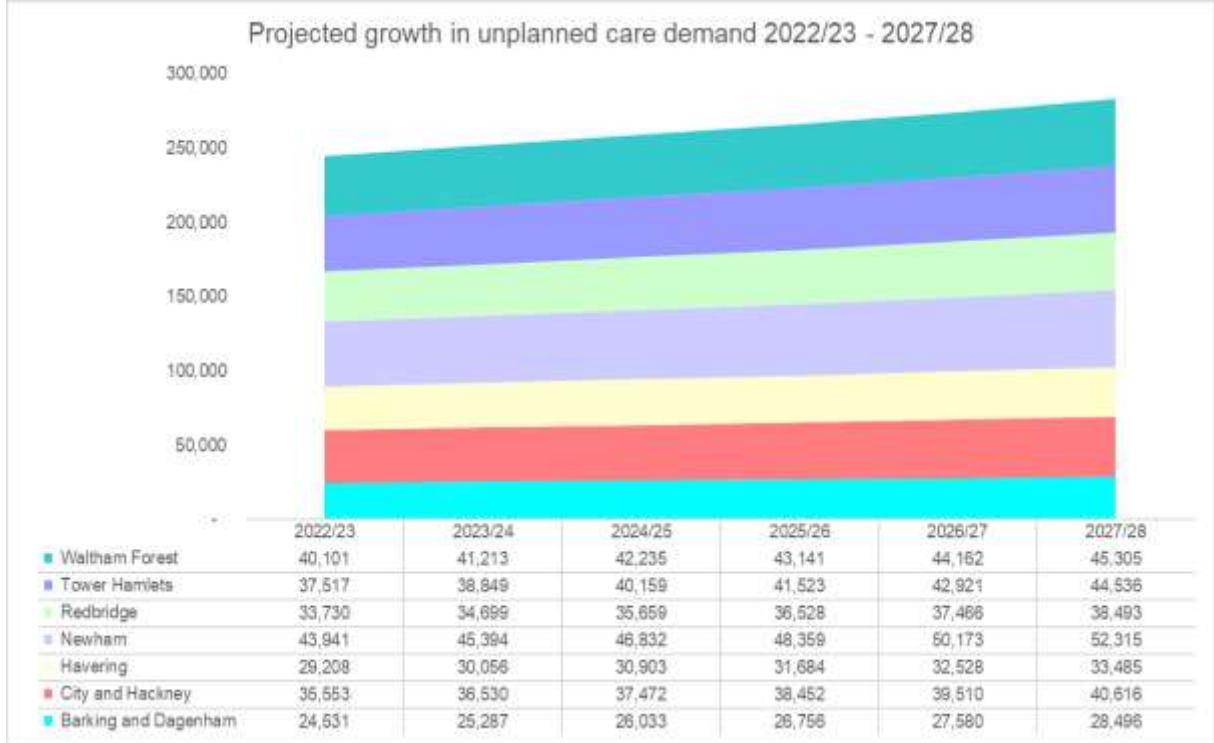
Demand projections for UEC

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

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

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

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

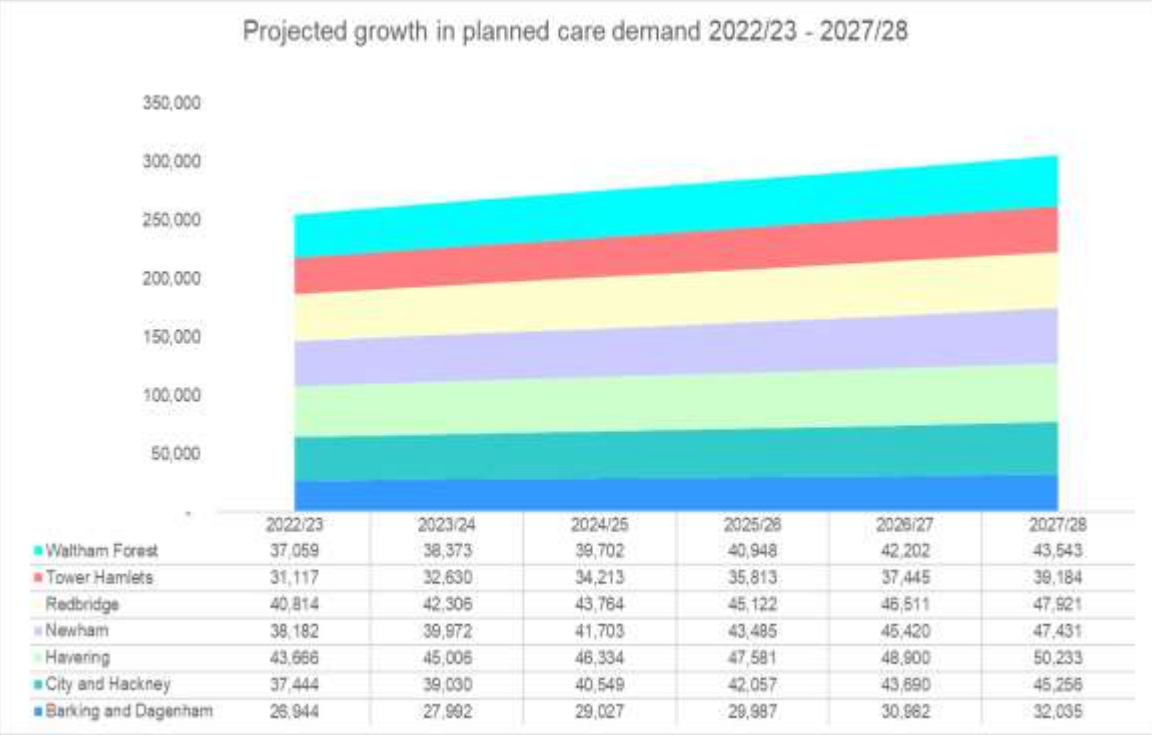


	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	40,101	41,213	42,235	43,141	44,162	45,305
Tower Hamlets	37,517	38,849	40,159	41,523	42,921	44,536
Redbridge	33,730	34,699	35,659	36,528	37,466	38,493
Newham	43,941	45,394	46,832	48,359	50,173	52,315
Havering	29,208	30,056	30,903	31,684	32,528	33,485
City and Hackney	35,553	36,530	37,472	38,452	39,510	40,616
Barking and Dagenham	24,631	25,287	26,033	26,756	27,580	28,496

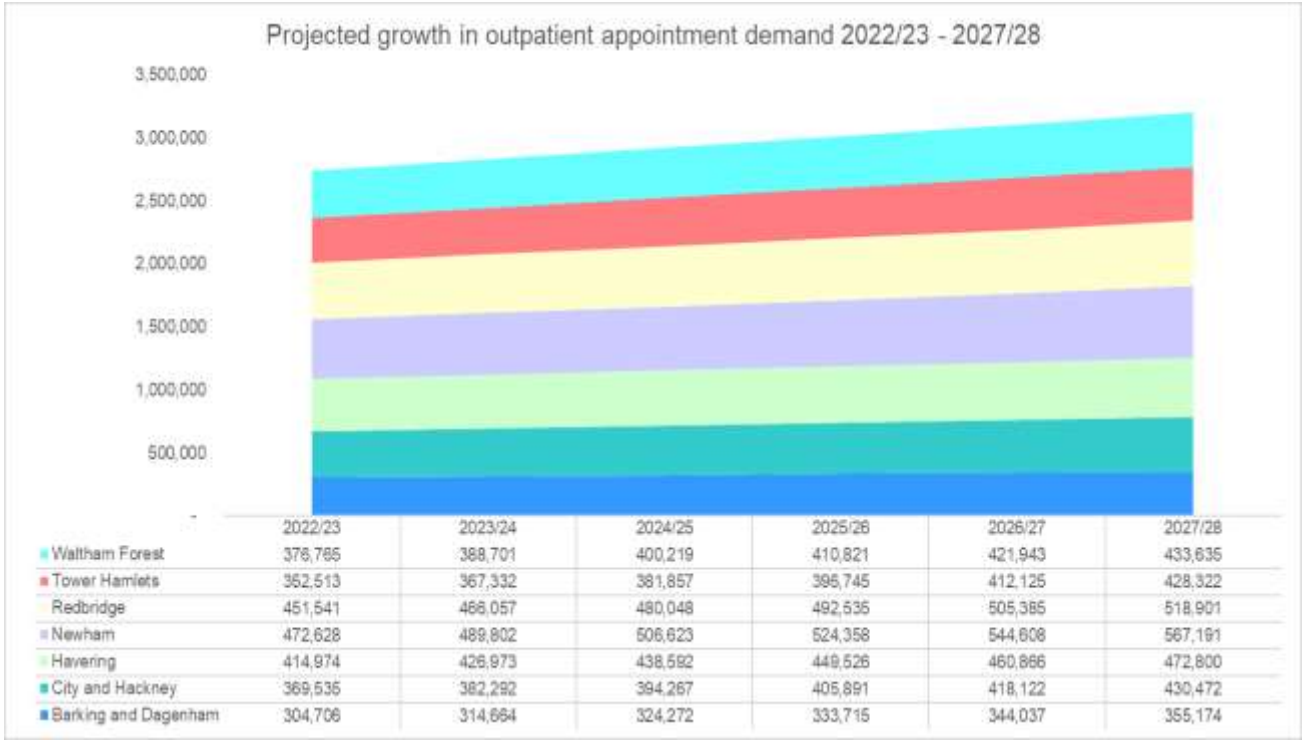
Figures are based on modelling by the NEL Insights Team which uses GLA population growth projections

Demand projections for planned care

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



	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	37,059	38,373	39,702	40,948	42,202	43,543
Tower Hamlets	31,117	32,630	34,213	35,813	37,445	39,184
Redbridge	40,814	42,306	43,764	45,122	46,511	47,921
Newham	38,182	39,972	41,703	43,485	45,420	47,431
Havering	43,666	45,006	46,334	47,581	48,900	50,233
City and Hackney	37,444	39,030	40,549	42,057	43,690	45,256
Barking and Dagenham	26,944	27,992	29,027	29,987	30,962	32,035



	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	376,765	388,701	400,219	410,821	421,943	433,635
Tower Hamlets	352,513	367,332	381,857	395,745	412,125	428,322
Redbridge	451,541	466,057	480,048	492,535	505,385	518,901
Newham	472,628	489,802	506,623	524,358	544,608	567,191
Havering	414,974	426,973	438,592	449,526	460,866	472,800
City and Hackney	369,535	382,292	394,267	405,891	418,122	430,472
Barking and Dagenham	304,706	314,664	324,272	333,715	344,037	355,174

Demand projections for diagnostics

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

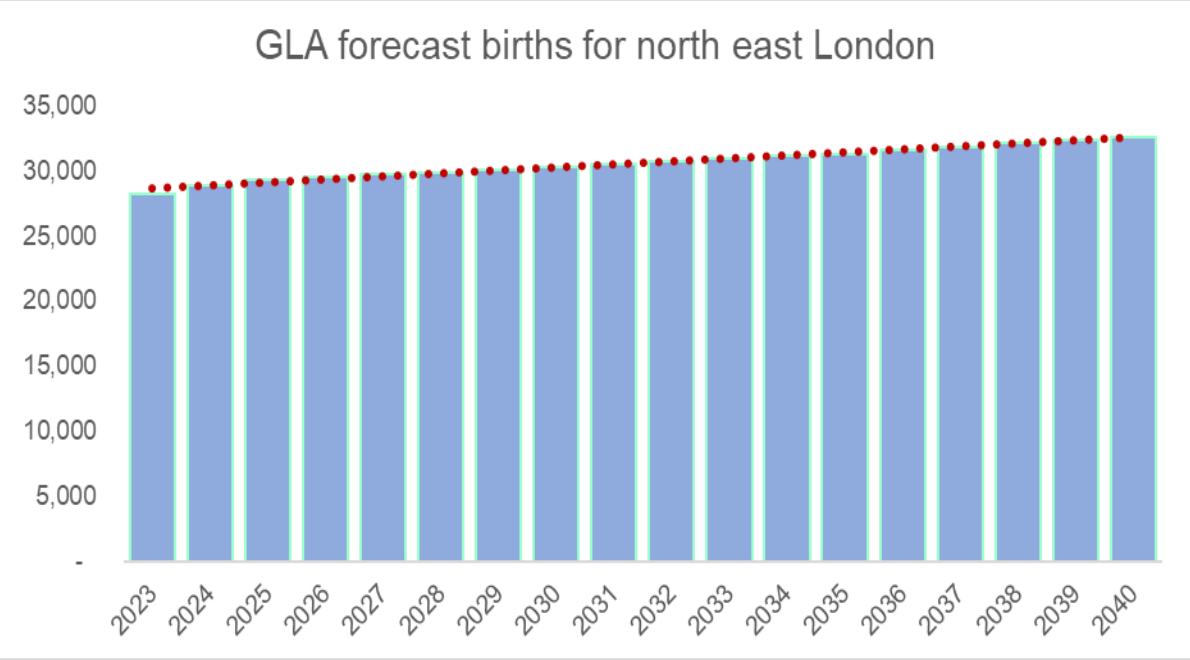
Imaging diagnostics projected demand growth 2022/23 - 2027/28								
	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Growth	5 year trend
Cone Beam CT	1,515	1,557	1,599	1,643	1,690	1,738	14.7%	
CT Scan	214,182	223,675	233,001	242,000	251,320	261,346	22.0%	
Endoscopy	1,668	1,744	1,818	1,888	1,962	2,041	22.4%	
Fluoroscopy	29,532	30,780	31,998	33,160	34,398	35,674	20.8%	
Medical photography	14	14	15	16	16	18	28.6%	
MRI	199,421	206,903	214,152	221,127	228,537	236,128	18.4%	
Nuclear Medicine	17,546	18,281	18,984	19,665	20,389	21,148	20.5%	
PET-CT Scan	6,098	6,388	6,682	6,955	7,247	7,539	23.6%	
SPECT Scan	1,253	1,302	1,344	1,385	1,424	1,463	16.8%	
Ultrasound	565,530	583,749	601,181	617,962	635,933	655,186	15.9%	
X-ray	884,831	918,064	950,447	981,507	1,014,316	1,048,943	18.5%	
All imaging	**1,921,590**	**1,992,457**	**2,061,221**	**2,127,308**	**2,197,232**	**2,271,224**	**18.2%**	

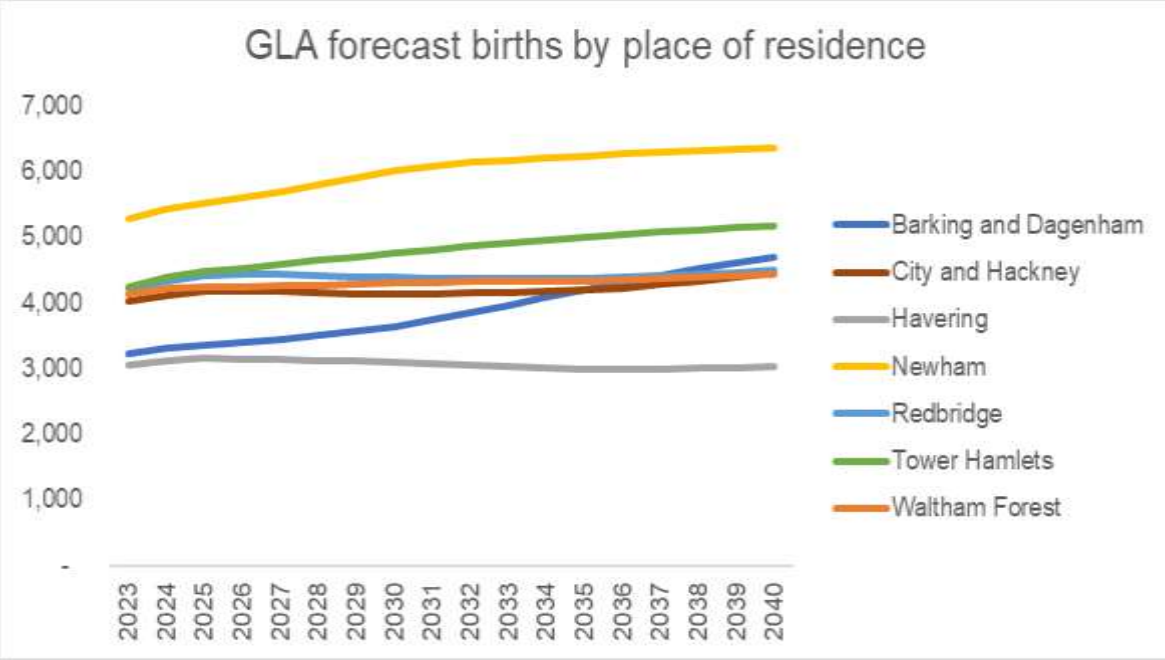
Demand projections for maternity

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

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

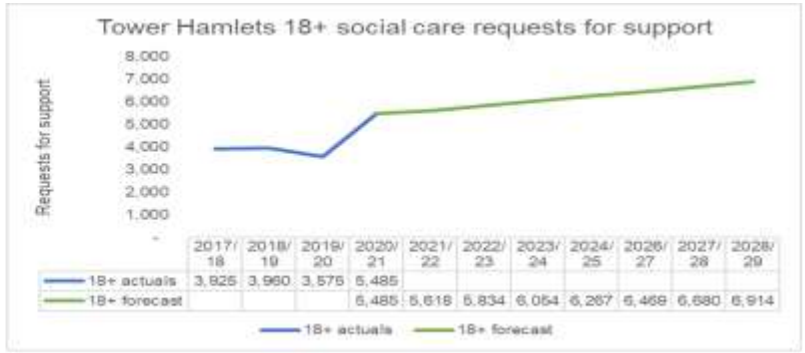
Havering forecast a reducing number of births between 2026 and 2036.

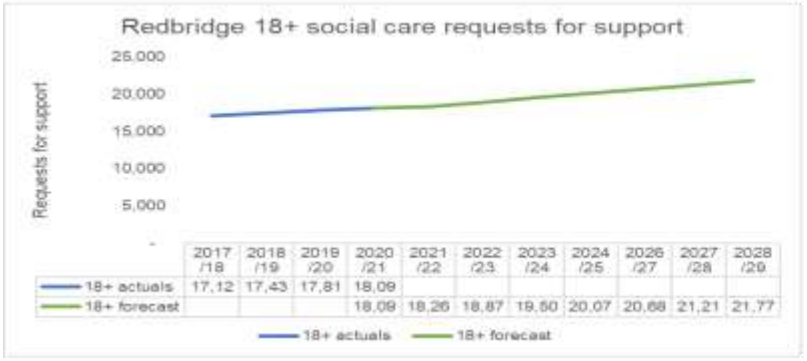


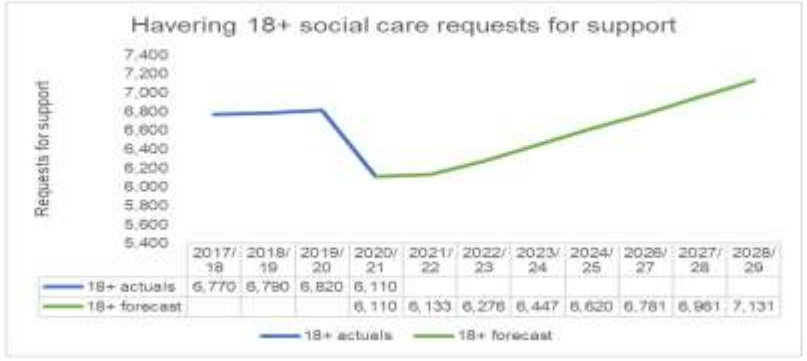


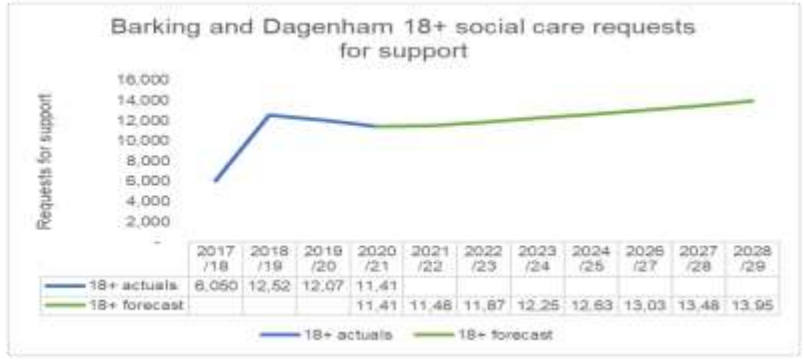
Demand projections for social care

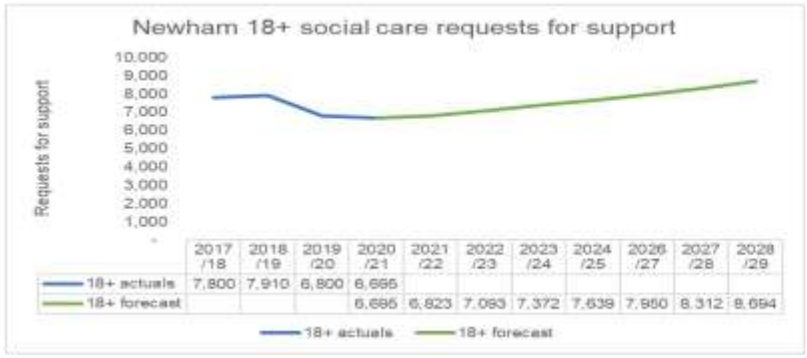
- This forecast is based on social care social care data showing number of requests for support received from new clients aged 18+.
- Approach to high level model:
  - Demographic growth assumption based on GLA housing led population projection (2021-based identified capacity scenario)
  - Non-demographic growth assumption of 1% p.a. agreed with client
  - Trend-based forecast uses an ordinary least squares linear regression model
- We will work with our local authority partners to develop this model further.

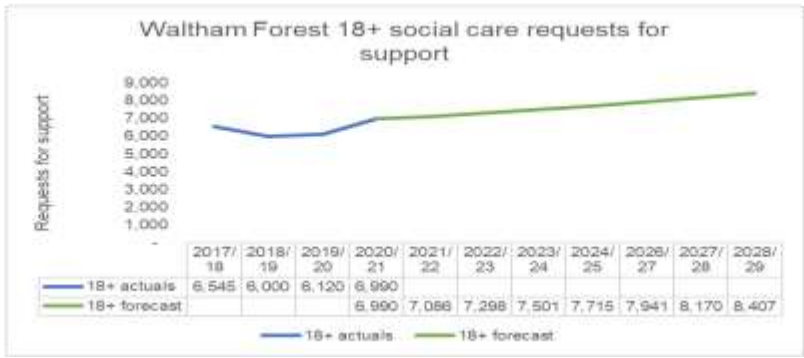


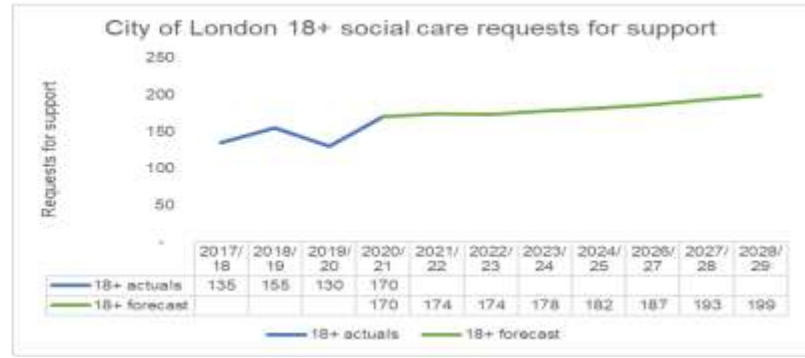










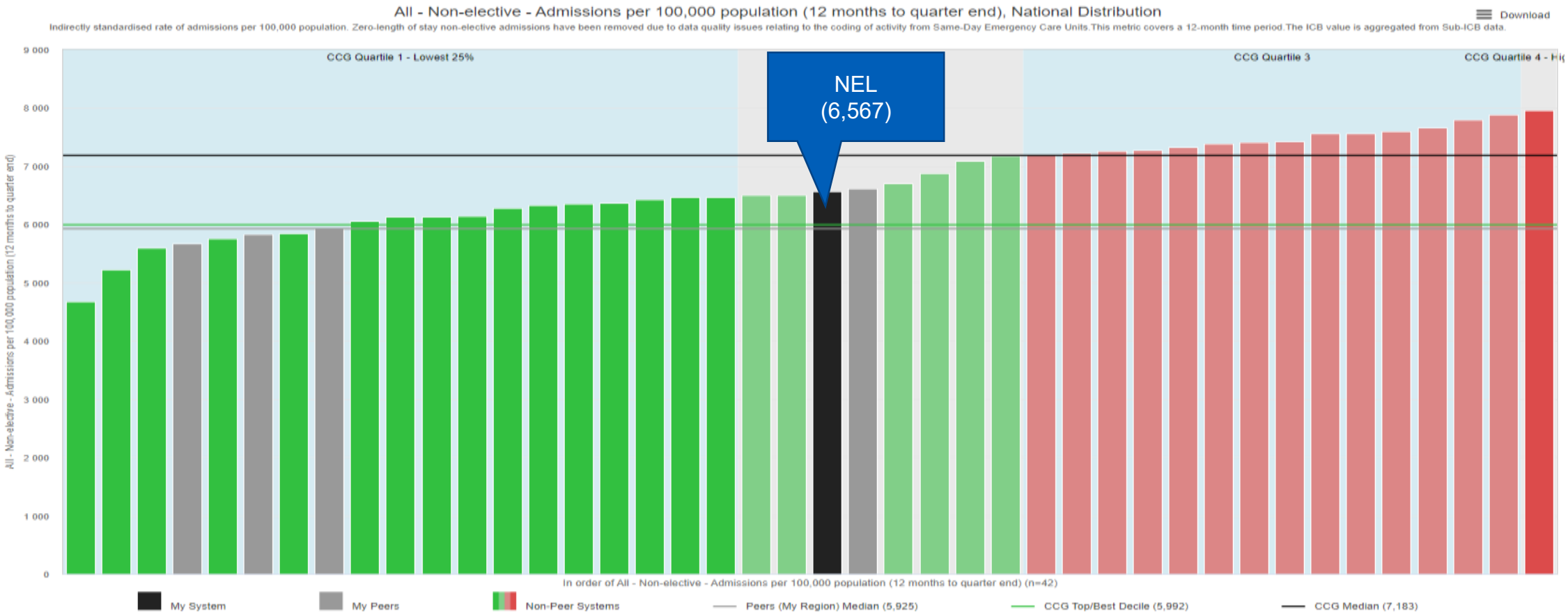


Annex 9B - Benchmarking

Urgent and Emergency care benchmarking

Non-elective admission rates

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

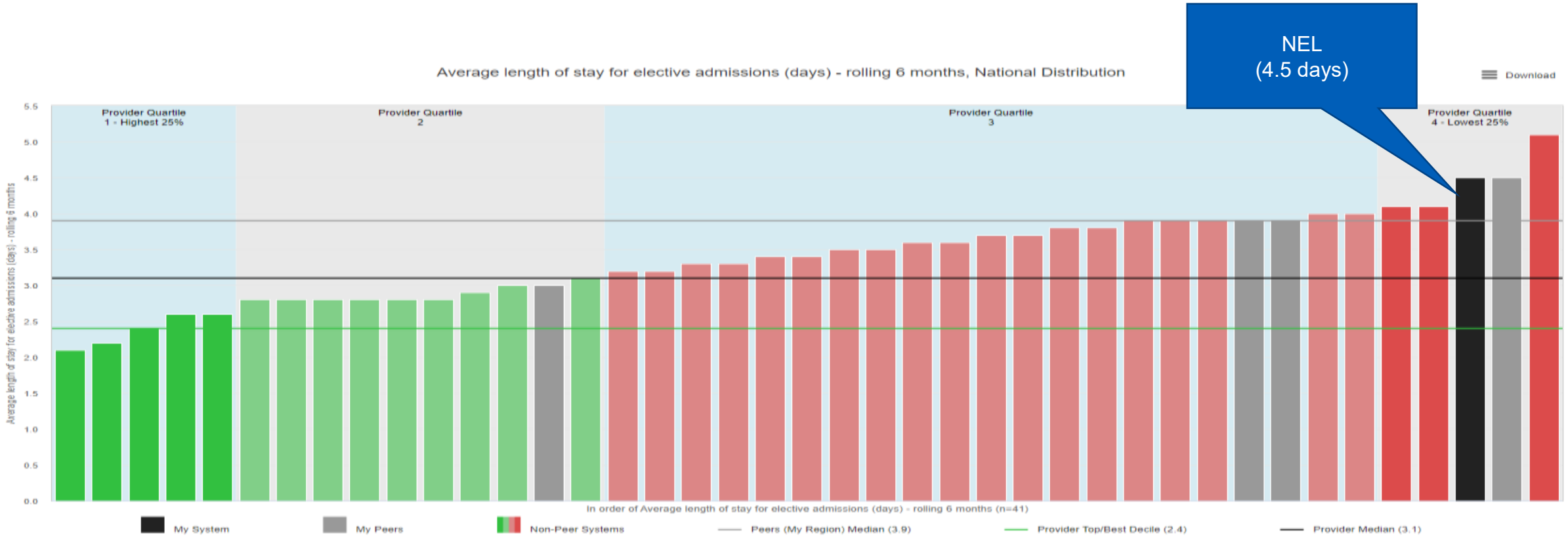


Data is from 'Model Health System' and covers a 12-month period, ending Q2 2022/23.

Elective care benchmarking

LOS for elective admissions

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



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

Annex 9C - improvement opportunities data

UEC – opportunities for improvement

Waiting list management

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

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

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

UEC – opportunities for improvement

Avoidable admissions

Emergency admissions for conditions not usually requiring hospital treatment

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

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

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

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

Unplanned hospitalisations for chronic ambulatory care sensitive conditions

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

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

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

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

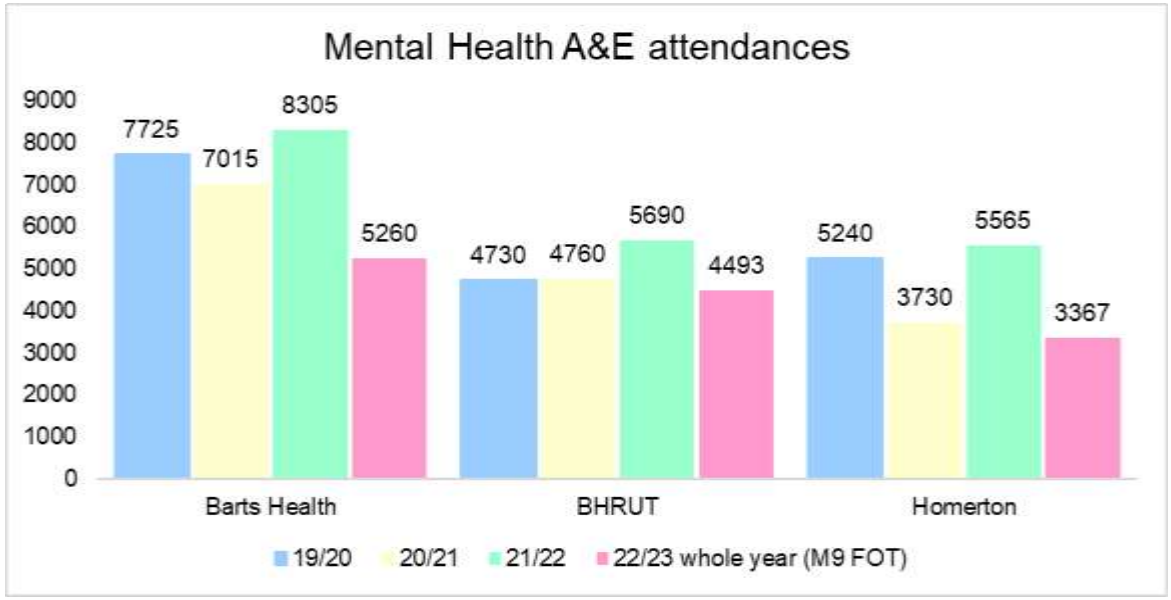
Among the 273 NEL practices included as operational during the period of this analysis, 46 practices have a rate that is identified as a (statistically significant) high outlier compared to rates at all NEL practices and accounting for the underlying practice populations

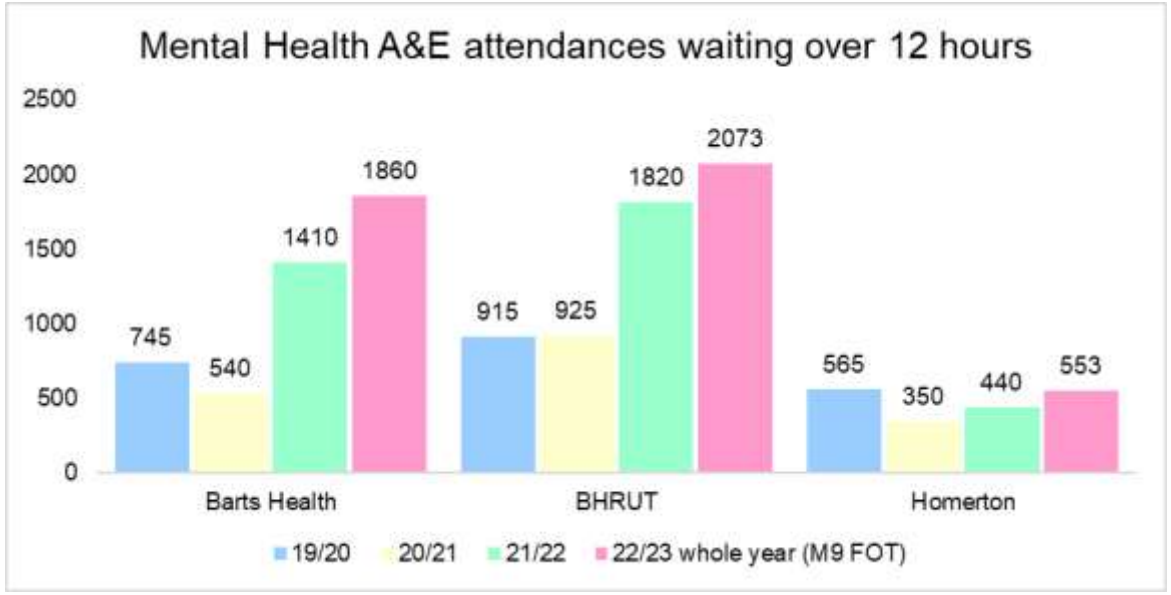
UEC – opportunities for improvement

Mental health patients in A&E

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

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





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

The size of children's social care in East London

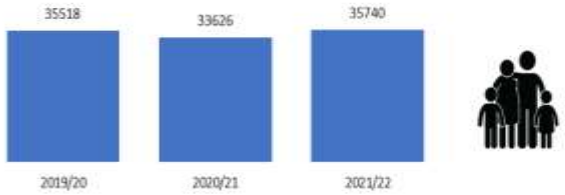
Children social care numbers

1st April 2021-31st March 2022

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

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

Children in need 3-year trend



The total number of children in need at any point in the last three years has increased to 35,740 children, this figure includes children looked after and care experienced young people aged 17 to 21 years of age. Responsibility for care experienced young people can extend to their 25th birthday.

(Hackney numbers have been based on 2019/20 figures)

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

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

Community service mapping – Unplanned / planned

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

Community service mapping – Adult therapies, equipment & coordination

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

Community Service Mapping – specialist services

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

Annex 9D - transformation portfolio

The transformation portfolio:

core elements of high-quality care and a sustainable system

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

The transformation portfolio:

core elements of high-quality care and a sustainable system

Core elements of high-quality care and a sustainable system (taken from the 'Recovering our core services and improving productivity' section of NHS operating guidance)			
Service area	Programme	Lead system partner	Page*
Primary care	Digital First	Primary care collaborative	28
	Same-day access		29
	Tackling unwarranted variation, levelling up and addressing inequalities		30
Planned care and diagnostics	Planned care	Acute provider collaborative	31
Cancer	Cancer alliance		32
Maternity	Maternity		33
	Maternity	NHS NEL	34
	Maternity safety and quality assurance programme	NHS NEL	35

The transformation portfolio:

additional local strategic priorities

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

The transformation portfolio:

additional local strategic priorities

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

The transformation portfolio:

additional local strategic priorities

Additional local strategic priorities			
Priority	Programme	Lead system partner	Page*
Mental health – to transform accessibility to, experience of and outcomes from mental health services and well-being support for the people of north east London	Perinatal mental health improvement network	Mental health, learning disabilities, and autism collaborative	68
	IAPT improvement network		69
	Improving health outcomes and choice for people with severe mental illness		70
	Improving outcomes and experience for people with dementia		71
	Crisis improvement network		72
	CYP mental health improvement network		73
	Mental Health	City and Hackney place partnership	74
	Mental health	Havering place partnership	75
	Adult Mental Health	Newham place partnership	76
	Mental Health	Tower Hamlets place partnership	77
	Mental Health	Waltham Forest place partnership	78
Employment and workforce – to work together to create meaningful work opportunities and employment for people in north east London now and in the future	Workforce transformation	NHS NEL	79
	BHR Health and Care Workforce Academy	B&D, Havering, and Redbridge place partnerships	80
Infrastructure	Digital infrastructure	NHS NEL	81
	Physical infrastructure		85

The transformation portfolio:

further local priorities

Further local priorities		
Led by	Programme	Page*
Acute provider collaborative	Critical care	86
	Research and clinical trials	87
	Specialist services (also see p53 to 58)	88
Mental health, learning disabilities, and autism collaborative	Lived experience leadership programme	89
	Learning disabilities and autism improvement programme	90
Barking and Dagenham place partnership	Ageing well	91
	Healthier weight	92
	Stop smoking	93
	Estates	94
City and Hackney place partnership	Supporting with the cost of living	95
	Population health	96
	Neighbourhoods programme	97
Havering place partnership	Infrastructure and enablers	98
	Building community resilience	99
	St George's health and wellbeing hub	100
	Living well	101
	Ageing well	102
Newham	Frailty model	103
	Neighbourhood model	104
	Population growth	105

Further local priorities		
Led by	Programme	Page*
Newham	Learning disabilities and autism	106
	Ageing well	107
	Primary care	108
Redbridge place partnership	Health inequalities	109
	Accelerator priorities	110
	Development of the Ilford Exchange	111
Tower Hamlets place partnership	Living well	112
	Promoting independence	113
Waltham Forest place partnership	Centre of excellence	114
	Care closer to home	115
	Home first	116
	Learning disabilities and autism	117
	Wellbeing	118
NHS North East London	Tobacco dependence programme	119
	NEL homelessness programme	120
	Anchors programme	121
	Net zero (ICS Green Plan)	122
	Refugees and asylum seekers	123
	Discharge pathways programme	124
	Pharmacy and Medicine Optimisation/ NEL	125

work in progress

North East London Health & Care Partnership

Joint Forward Plan

Delivering our ambitions through a system transformation portfolio

Transformation portfolio reference document

Third draft: 21 March 2023

The transformation portfolio:

core elements of high-quality care and a sustainable system

North East London Health & Care Partnership

Core elements of high-quality care and a sustainable system (taken from the 'Recovering our core services and improving productivity' section of NHS operating guidance)			
Service area	**Programme**	**Lead system partner**	Page*
Urgent and emergency care	Urgent and emergency care	Acute provider collaborative	8
	Enhanced health in care homes	Community collaborative	9
	Ageing well (focussed on urgent community response)		10
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		Tower Hamlets Place Partnership	26
		Waltham Forest Place Partnership	27

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

North East London Health & Care Partnership

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Maternity	Maternity		33
	Maternity	NHS NEL	34
	Maternity safety and quality assurance programme	NHS NEL	35

The transformation portfolio: additional local strategic priorities

North East London Health & Care Partnership

Additional local strategic priorities			
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The transformation portfolio: additional local strategic priorities

North East London Health & Care Partnership

Additional local strategic priorities			
Priority	**Programme**	**Lead system partner**	Page*
Long-term conditions (continued)	CVD	NHS NEL	51
	Diabetes	NHS NEL	52
	Neurosciences	NHS NEL	53
	Renal	NHS NEL	54
	Respiratory	NHS NEL	55
	HIV	NHS NEL	56
	Hepatitis and liver	NHS NEL	57
	Haemoglobinopathy	NHS NEL	58
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The transformation portfolio: additional local strategic priorities

North East London Health & Care Partnership

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	Physical infrastructure		84

The transformation portfolio: further local priorities

North East London Health & Care Partnership

Further local priorities		
Led by	**Programme**	Page*
Acute provider collaborative	Critical care	85
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	Refugees and asylum seekers	122
	Discharge pathways programme	123
	Pharmacy and Medicine Optimisation/ NEL	124

Note: further work is being done ahead of the end of March submission on the programme descriptions from the acute provider collaborative, BCYP, LTC – diabetes, and some of the place partnerships

Standard template: transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Workstream focus on:

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

Further transformation to be planned in this area:

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

Programme funding:

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

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

Further transformation to be planned in this area:

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

Over years three to five
- To have fully embedded co-creation in service design with care providers including joint commissioning

Leadership and governance arrangements:

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

Programme funding:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

April 2024:

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

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

Programme funding: NHSE (National Funding)

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

April 2024:

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

April 2026:

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

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

Further transformation to be planned in this area:

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

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

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

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

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

- Ageing Well
- Virtual Ward

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

- Ageing Well for Rapid Response
- Virtual Ward Funding

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

- Ageing Well
- Virtual Ward SDF

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

- X

Leadership and governance arrangements:

- Newham Urgent Care Working Group
- Newham Front Door Programme

Key delivery risks currently being mitigated:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

- X

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

- X

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

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

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

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

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

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

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

Further transformation to be planned in this area:

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

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

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

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

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

- Workforce development
- Transition to BAU

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

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

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

April 2024:

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

April 2026:

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

Over the next two years

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

Programme funding: NHSE (National Funding)

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

April 2024:

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

April 2025

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Same day access - primary care / NEL/ SRO TBC

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

The benefits that all NEL residents will experience by:

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Standard template: transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Key milestones include:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Standard template: transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

April 2024:

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

April 2026:

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

Over the next two years

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

Over years three to five

Maternity digital care records: Single Digital system across NEL

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

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

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

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

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

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

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

Key programme features and milestones:

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

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

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

April 2024:

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

April 2026:

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

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

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

Over the next two years

- Work up priorities and implementation approach

Over years three to five

- Build prevention workforce capacity/capability

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

- Build upon and increase existing community capacity, aligning to family hubs and strengthening adolescent healthcare. Through social prescribing and multi-disciplinary teams we will enable links to community assets including the community and voluntary sector and put health inequalities at the heart of our work
- Developing integrated care models and pathways for children across primary secondary and community care
- Give patients and (with patient consent) carers and clinicians involved in their care, better access to their care record

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

- Collaboration between education, health and social care to ensure school readiness for all children and to meet the needs of children with special educational needs and disabilities.
- Improving the experience and support available for all children as they transition to adult services
- Improving access to children and young people's emotional health and mental health services
- Increasing access to prevention and self-management for children and young people with diabetes
- Increasing access to specialist epilepsy support for children including those with learning disabilities and autism
- Improved earlier diagnosis and support pathways for children and SEND and their families

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

Build upon and increase existing community capacity, aligning to family hubs and strengthening adolescent healthcare. Through social prescribing and multi-disciplinary teams we will enable links to community assets including the community and voluntary sector and put health inequalities at the heart of our work

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

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

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

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

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Over the next 3-5 years

There is consistency of quality and standards across NEL w

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Over the next 3-5 years

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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

Transformation in NEL

North East London Health & Care Partnership

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

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

ASD - by April 2024:

- A dedicated hub and spoke ASD service delivering best practice diagnosis and both pre and post diagnosis support for children and families
- An expanded supernumerary clinical and support ASD team working to eliminate backlogs and deliver defined diagnosis and follow up waiting times
- A single point of access to the dedicated Autism team including SALT, Psychologists and Paediatricians
- Elimination of area variance through the establishment of SOP for referral, screening, needs-based support
- Best practice transition arrangements with additional specific criteria to manage 18–25-year-olds
- Elimination of clinical backlogs and the release of existing CAMHS resources into EWMHS provision
- Wider integrated LDA provisions within Primary Care and secondary care with MDT provisions and sensory adjustments

ASD – by April 2026:

- A dedicated clinical workforce able to fully meet the needs of the service users
- Referral to ASD diagnostic assessment waiting time of 13 weeks;
- Waiting time to follow up appointment following ASD diagnostic assessment of 6 weeks
- A fully NICE compliant ASD service
- Meeting the strategic objectives of the roadmap for the national 5-year strategy for autistic children and young people and complying with the Autism Act 2009.

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

- Facilitation of timely diagnosis families with Autistic children supporting integrated system responses to vulnerable LDA service users
- Pre and post diagnosis support (including 3rd sector) for families with vulnerable children with cultural adjustments to reflect inequity of current provisions
- Cultural adjusted and targeted health promotion & training in the community with education & training strategies to enable self-management for patients and families
- Support within the wider SEND structures for those CYP with additional and complex needs including sensory adjustments in BCYP service provision

Key programme features and milestones:

- Soft ' launch January 2023 – all new referrals where ASD is suspected will be managed in the new ASD pathway team. Existing patients are still with locality teams but further integration is part of the whole transformation programme.
- Referral routes don't change as the locality hubs across BHR will process all referrals as usual and ensure that the new ASD service receive the referral. Patients will be seen in local venues to them across BHR so provision will work on a hub and spoke model
- Aim to deliver NICE concordant offer in a more timely way

Further transformation to be planned in this area:

- Over the next two years
  - An on-going programme to deliver expanded ASD provisions aligned with Phase funding

Programme funding:

- Phase 1 funding confirmed
- Funding for subsequent Phase roll out within system

Leadership and governance arrangements:

- Multi-agency working group
- CYP Transformation Board, NEL BCYP delivery Board
- Area based PbP

Key delivery risks currently being mitigated:

- Follow up Phase funding issues present a significant risk to the delivery of the full NICE compliant provision
- Recruitment is a risk so we established links to new Clinical and Professional Leads and working in partnership with Professor Baron Cohen and the team at Cambridge University

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

BHR Paediatric Integrated Nursing Service (PINS) SRO Tracy Rubery

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

- Establishment of major components within a community nursing services for children delivering care within a best practice integrated model including LTC management, complex and continuing care, continence and EOLC
- Parents attending ED to be offered support within community provision and alternative discharge options to acute observation
- An integrated Health / Social Care and 3rd sector service mirroring NWL Connecting Care for Children and centred around an MDT 'Hub' and providing holistic support for family needs
- Complex children and their families to be receiving continuity of care through a model of provision spanning the home and education environments

PINS – by April 2026:

- Full alternative ED referral route into an integrated community provision (Hospital @ Home)
- Vulnerable children cared for within an holistic complex pathway model across both home and school
- Children with level 2 continence needs have fast access to specialised support in the community
- BCYP with LTC supported by dedicated CNS working within an integrated support system
- Specialist EOLC available within wrap around service provision

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

- The integrated provisions address the social determinants of health
- Complex pathway children are the most vulnerable and disadvantaged in society
- Significant % of the relevant cohorts have LDA needs
- The CC4C model targets families in greatest need
- Asthma, allergy and sickle cell are over represented within disadvantaged groups

Key programme features and milestones:

- Hospital @ Home live from April 2023
- Common CCNT model established within 2023/24
- Best practice continence service awaiting funding 2023/24
- CC4C 'Hubs' operational by Q2 2023/24
- EOLC model in place
- Complex Pathway model multi agency sign off within 2023/24

Further transformation to be planned in this area:

- Over the next two years
  - Further improvements in integrated provision
  - Further improvements targeted provisions

Programme funding:

- Funding for Hospital @ Home agreed
- Funding for expanded continence provision awaiting confirmation
- EOLC funding agreed

Leadership and governance arrangements:

- Multi Agency working groups delivering models
- Redbridge PBP is lead for the PINS programme
- Revised ToR and membership for Complex Pathway

Key delivery risks currently being mitigated:

- Investment delay is a significant risk to the delivery of these integrated services seeking to reduce pressures on primary and acute care
- Complex pathway requires political management due to multi-

Alignment to the integrated care strategy

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

Transformation in NEL

North East London Health & Care Partnership

Babies, Children and Young People / Newham Place-Based Partnership / Sarah Wilson, Director of Specialist Services (Children's), ELFT sarah.wilson48@nhs.net and Tim Aldridge, Director of Children's Services, LBN Tim.Aldridge@newham.gov.uk

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

- April 2024:
  - Improved access to community-based services when babies, children and young people need them
  - Access to more integrated services in one place
  - Improved SEND provision and outcomes

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

- By identifying and agreeing priorities that are locally focussed based on data and evidence
- By focussing on universal to specialist level of needs using population health management approaches
- By having a strengthened focus on equity, equality and challenging racism and all forms of discrimination
- By working with and across all system partners, with a strengthened focus on residents voice from the start of any project

Key programme features and milestones:

- April 2023 – Agree a small number of initial priorities for partners to work together to deliver better outcomes for residents, staff and the system
- Speech and language therapy
- Roll out family hubs with a range of integrated services
- Improve outcomes for women, birth people and babies with a focus on inequities
- Develop our MH offer including for those with the most complex needs
- Integrate care across primary, community and secondary care with a focus on LTCs, MDTs and our youth zone offer
- Continued improvement of the SEND support offer

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

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

Leadership and governance arrangements:

- Newham Babies, Children and Young People Joint Planning Group chaired by the SROs, which reports up to the Newham Health and Care Partnership Board and NEL BCYP Joint Committee

Key delivery risks currently being mitigated:

- X
- X

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Pan BHR SEND Therapy Provision SRO Sharon Morrow

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

SEND Therapy Provision - by April 2024:

- Pupils in identified special schools will have their AHP needs met though a new model of joint working between Health and Education with increases in therapy provision and reductions in wait times
- Outcomes from Workforce Academy programmes should deliver additional AHPS and shorten wait times
- Outcomes from Workforce Academy programmes should deliver additional AHPS and allow greater use of tailored inputs

SEND Therapy Provision – by April 2026:

- Workforce Academy planning will increase the availability of timely therapy intervention
- Integrated Phase 2 ASD programme roll out will be bringing an integrated model of working to vulnerable service users to assist them and their families both pre and post diagnosis

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

- CYP needing SEND therapies are amongst the most vulnerable in society
- There is a strong correlation between SEND needs (especially SALT) and social deprivation
- Early and appropriate interventions positively affect lifelong levels of achievement

Key programme features and milestones:

- Pan NEL adoption of the Workforce Academy programme Q1 2023/24
- Outcomes from Astrum Pilot demonstrating revised model of working Q2/3 2023/24
- Parity AHP business cases emerging from SEND baseline workstream and community collaborative inputs Q1 2023/24
- Significant issues remain with parity and capacity of CYP AHP provision across BHR Boroughs

Further transformation to be planned in this area:

- Over the next 2 years significant investment needed to meet the pressures identified in the multi-agency SEND baseline review
- Outcomes and KLOES from Joint OFSTED/CQC area inspections

Programme funding:

- TBC in support of Joint area inspection outcomes and parity business cases

Leadership and governance arrangements:

- Workforce Academy pan NEL with AHP workstream lead by Havering PBP Director
- Actions and governance primarily via PBP and SEND Executives

Key delivery risks currently being mitigated:

- Major risk is arising from recruitment and retention issues in NEL leading to wage inflation and INEL resource 'capture'
- Workforce Academy programme working to close Recruitment &Retention gap through revised methods of working

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

BHR Tier 3 NICE compliant Paediatric Obesity Service SRO Sharon Morrow

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

- Establishment of NICE compliant obesity Tier 3 provision taking learning from Complication from Excess Weight Clinics (CEWS)' pilot schemes
- A multi-disciplinary team utilising dietitians, psychologists, family therapists, exercise support worker, physicians and other experts to develop a tailored/individualised care plan.
- Reductions in immediate and lifelong health and emotional issues through early systemic intervention
- Specific reductions in LTC such as diabetes

Paeds Obesity Service – by April 2026:

- A fully integrated multi-agency weight management service covering Tiers 1-4

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

- Reduced inequalities across our population due to higher rates in CYP living in economically deprived areas, those of certain ethnic minority heritages and girls
- Early intervention reducing lifetime health and EWMH issues within those identified as having inequity of opportunity and outcomes

Key programme features and milestones:

- Further modelling to be undertaken to identify activity and forecast demand for service
- Development of comprehensive multi-agency service specification
- Submission of robust business case
- Securement of initial investment

Further transformation to be planned in this area:

- Over the next two years
  - Investment permits the roll out of the comprehensive multi-agency model as part of a best practice Tier 1-4 system

Programme funding:

- TBC

Leadership and governance arrangements:

- The T3 WMS via BHR HCC through the overarching BHR Obesity action Plan. The T3 WMS forms one action as part of 14 strong action plan on obesity. Subject to governance revision

Key delivery risks currently being mitigated:

- There are no T3 Paediatric WMS service at present and so the identified risks and consequences include continuing to provide inadequate WMS not meeting NICE quality standards, levels of obesity will continue to worsen

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Born Well, Grow Well / Tower Hamlets / Warwick Tomsett, Borough Director Tower Hamlets, NHS NEL Warwick.Tomsett@towerhamlets.gov.uk

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

- Enhanced access to, and experience of, mental health services for children and young people
- Improved SEND provision and outcomes
- Fewer children and young people that are obese or overweight
- Access to more integrated services in one place, starting with Early Help provision
- Support for families to mitigate the impact of the cost of living crisis

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

- By addressing inequalities that exist in provision of mental health services, ensuring that any gaps in outcomes for children and young people from different backgrounds are addressed
- By mitigating the impact of the **cost of living crisis** on more **deprived families**
- By ensuring that those with SEND are able to access the services they need and are assisted to achieve their potential
- By addressing inequalities that are causing higher obesity levels in children and young people from certain backgrounds more than others, using a targeted approach where required

Key programme features and milestones:

- Mental health services: A programme with 17 projects has been developed for delivery which includes: Tower Hamlets Education Wellbeing Service, CAMHS personal health budgets, extended Crisis hours, an eating disorder service, support for sexual abuse victims.
- Improved SEND provision focuses on: leading SEND, early identification and assessment, commissioning effective services, good quality education provision & supporting successful transitions.
- Tackling childhood obesity has 3 focus areas: healthy places, healthy settings, healthy services.
- More integrated services plans to start with the ambition of creating an effective Early Help Eco system with a common practice approach

Further transformation to be planned in this area:

- Over the next two years
  - Development of existing key programmes to be determined in the next 2 years
  - Programme mapping – to identify gaps in integration

Over years three to five

- Transformation plans to be confirmed i.e. phasing, scope and milestones

Programme funding:

- Core based budgets from LBTH and ICB
- Health Inequalities funding
- Public Health
- Mental Health Investment Standards

Leadership and governance arrangements:

- Principal strategic and operational oversight by Children and Families Executive Board
- Monthly delivery oversight by Local Delivery Board
- Quarterly assurance monitoring at THT Executive Board

Key delivery risks currently being mitigated:

- Project management support
- Gap in data and data insights

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

BCYP / Waltham Forest / Sue Boon, Director of Partnership, Impact & Delivery Waltham Forest, NHS NEL, sue.boon@nelft.nhs.uk

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

- April 2024:
  - Have an agreed joint partnership strategy for BCYP
  - Improved knowledge and access to health services, reducing the number of frequent attenders at ED
  - Improved support for BCYP presenting at ED with asthma
  - Hospital @ Home will improve outcomes for BCYP with health needs
- April 2026:
  - Residents will experience joined up working between BCYP services across Waltham Forest
  - Increased access to mental health support at an early intervention/prevention stage in the community

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

- By linking with the evidence and action plan of the Marmot Review
- By identifying the reasons for people frequently attending ED, and supporting identified inequalities in accessing services
- By developing the BCYP strategy, we will include health inequalities and identify actions to reduce health inequalities
- By increasing early intervention opportunities and community MH services for cyp, we will reduce inequalities in access

Key programme features and milestones:

- BCYP strategy – by summer 2023
- Implementation of Frequent Attender project
- Business Case for 48 hour reviews for asthma
- Implementation and evaluation of H@H service

Further transformation to be planned in this area:

- Over the next two years
  - Improved access for CYP with LD in primary care and acute setting
  - MDTs in primary care for CYP
- Over years three to five
  - X

Programme funding:

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

Leadership and governance arrangements:

- BCYP Executive Group – sub group of place based partnership board
- X

Key delivery risks currently being mitigated:

- Workforce – issues in both MH and Primary Care
- Increased demand and acuity for services
- Ability to invest long term in areas that will reduce inequality whilst still trying to meet acute demand
- BCYP often get 'lost' in all age programmes, resulting in

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Cardiovascular Disease / NEL / SRO: Charlotte Stone, programme Director, NHS NEL -charlotte.stone14@nhs.net

The benefits that NEL residents will experience by April 2024 and 2029:

By 2024

- Cardiac Rehabilitation – by 2024 all eligible residents across NEL will have equitable access to Cardiac Rehabilitation services (Whipps Cross service to go live by 2024), and to ensure high quality services across all areas (pathway to green certification across all services)
- Improved for Lipid Management across NEL – delivered by targeted projects in Waltham Forest and Barking & Dagenham and Newham (targeted health inequalities projects).
- Improved uptake of BP monitoring delivered via BP@Home
- Improved BP detection - via community pharmacy services and improved uptake of NHS Health Checks.
- Improved Heart Failure services – reviewing and developing a plan to action the recommendations of the audits conducted by the North London Cardiac Delivery Network and to ensure accessible and high quality services.
- Improved outcomes relating to CVD risk factors eg Lipids and hypertension – via LTC outcomes framework

By 2029

- Improve detection of atrial fibrillation and ensure appropriate stroke risk reduction through anticoagulation - by 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation.
- Improve detection of undiagnosed hypertension and ensure those with hypertension are controlled to target – by 2029 80% of expected numbers with hypertension are detected and 80% of people with high blood pressure are treated to target
- Improve the numbers of people who have had a CVD risk assessment and cholesterol check – by 2029 75% of people eligible have had a CVD risk assessment and cholesterol reading recorded on primary care data system in last 5 years
- Ensure patients who have a history of CVD are on optimal lipid lowering therapy and improve detection of Familial Hypercholesterolaemia (FH) – by 2029 45% of people aged 40-74 identified as having 20% or greater 10 year risk of developing CVD in primary care are treated with statins and 25% with FH are diagnosed and treated optimally.
- Improve access to and uptake of Cardiac Rehabilitation (CR) – by 2029 85% of eligible patients are accessing CR
- Improve diagnosis of Heart Failure (HF) and optimal management of patients with HF - 90% of people with HF will have an annual review

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

- By taking a population health approach and using insights and data to inform priorities, target inequalities and variation
- Targeting specific underserved populations in Barking & Dagenham and Newham with initiatives to increase the number of residents having CVD risk factors checks and improve the uptake of innovative lipid lowering therapies to minimise the risk of myocardial infarction and stroke
- Targeting specific underserved populations in Waltham Forest via delivery of initiatives to improve detection and optimisation of lipid management to minimise the risk of myocardial infarction and stroke
- Utilising Health Inequalities audit data to plan and develop Cardiac Rehabilitation services to improve uptake and completion of cardiac rehabilitation services
- Improving uptake of BP monitoring initiative in underserved populations – BP@Home champions

Key programme features and milestones:

- Establishing formal governance and programme infrastructure required to deliver this programme of work.
  - Formalise the cardiology relationship via structures agreed on 20.1.23 (Q4 22/23)
  - Develop a jointly-owned vascular and CVD plan (Q1 23/24
  - Develop a NEL CVD Strategy (Q2 23/24)
  - Establish governance for the working groups (Q4 23/24)
  - Set up working groups (Heart Failure, Hypertension Lipid Management, Atrial Fibrillation) (Q1 23/24)
- Agree pathway and innovations for the CVD Health Inequalities project (InHIP) (B&D and N) (Q4 22/23)
- Delivery of the InHIP project (Q1 –Q4323/24)
- Completion of the InHIP project (Q4 23/34)
- Roll out of the LTC outcomes framework (Q2 23/24) (led contractually by primary care) – impacting on benefits
- Increase in capacity of Cardiac Rehabilitation at Whipps Cross Hospital (Q1 23/24)
- Business case development for recurrent funding of Whipps Cross Cardiac Rehabilitation Services (date tbc)
- Optimisation of Lipid Management STF Project in Waltham Forest – initiation of project (Q1 23/24), Delivery of project (Q2 – Q4 23/24)
- Completion of Optimisation of Lipid Management STF project (Q4 23/24)

Further transformation to be planned in this area:

Over the next two to five years

- Development of CVD dashboards that provide actionable insights
- Scoping opportunities for standardising access and delivering care
- Business case to secure recurrent funding for Cardiac Rehab at Whipps Cross

Programme funding:

- SDF funding
- InHIP £100k,
- Whipps Cross £365k,
- STF project £134,250
- CVD Prevention Leadership £117k
- Local place transformation funding

Leadership and governance arrangements:

- Clinical leads (primary and secondary care), programme director, deputy LTC programme director, senior programme manager (WTE 0.5), deputy programme manager (WTE 0.5)
- NEL CVD Clinical Network
- Working groups - cardiac rehabilitation and establishing hypertension, atrial fibrillation, lipid management, heart failure
- Currently working to formalise the cardiology and cardiovascular disease joint working with the APC
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External governance by Cardiac ODN and regional and national programme

Key delivery risks currently being mitigated:

- ICB workforce capacity to support matrix working
- On-going clinical leadership at NEL and place
- Failure to formalise joint working agreements to link CVD & Cardiology affecting delivery of NEL wide plans to address regional, national and local ambitions.
- Financial reduction in NHS SDF funding in 23.24 (no mitigation)

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Diabetes / NEL and local place based leads / SRO Siobhan Harper, Workstream Director, NHS NEL Siobhan.harper@nhs.net

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

- April 2024:
  - **Improved outcomes** for people living with diabetes for people with diabetes by standardising diabetes care across primary, community and secondary care. Thresholds currently under development.
  - **Reduction of type 2 diagnoses / delayed onset** in residents developing Type 2 (T2) diabetes delivered through an increase the number of people referred and starting the National Diabetes Prevention Programme (DPP) 45% of eligible populations).
  - **Increase in the numbers** of people living with Type 2 diabetes who achieve T2 diabetes remission, delivered through increasing uptake of LCD (low Calorie Diet) national programme. Target 373 people.
  - **Improved self -management** delivered through an expansion of structured education and digital management tools. Target for uptake to structured education programmes XX and DWMP target to be confirmed by NHSE.
  - **Collaborative care planning** to support holistic assessment of need and agree individual care plans
  - **Personalised care** - population Health Management approach established to support risk stratification, cohort identification and optimal care interventions delivered through implementation of NEL LTC outcomes framework - diabetes
  - **Reduced length of stay** in hospital for people living with diabetes delivered through establishing NEL wide Diabetes inpatient specialist roles and Multi-disciplinary foot teams TBA
  - People living with diabetes can have more **confidence that a wide range of healthcare** staff understand how to manage diabetes delivered through diabetes workforce education programme
- April 2026:
  - Locally delivered TIDE (Type 1 disordered Eating) service
  - Robust transition pathways for children living with diabetes across NEL
  - Improved foetal outcomes for babies born to women with diabetes
  - Reduction in below and above knee amputations
  - Improved detection rates of Type 2 diabetes
  - Type 1 service framework embedded across NEL services

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

Utilisation of health inequalities data across 4 of the programme

- By utilising deep dive data analysis into local participation rates to support target local campaigns to improve equitable access by age, gender, ethnicity & deprivation
- By working with partners including providers, residents to review diabetes care pathways to reduce inequalities and improve equity to services e.g., uptake and completion rates of diabetes prevention, remission, structured education access to CGM (continuous glucose monitoring), insulin pumps.
- By piloting innovative approaches e.g. HI tools in primary care that identify residents that at the highest risk of developing Type 2 diabetes
- Undertaking gap analysis across acute settings in relation DISN / MDFT provision and ensuring there is service coverage across NEL
- By undertaking a population Health Management to support risk stratification, cohort identification and optimal care interventions utilisation of risk stratification tools in a primary care setting

Key programme features and milestones:

- Business case developed for MDFT in TH, N, WF (April 2023)
- Primary Care diabetes dashboard updated to include inequalities data (October 2023)
- Diabetes 23.24 & 25.26 priorities agreed – NEL & place based leads (March 2023)
- Type 1 service framework gap analysis undertaken (August 2023)
- TIED business case developed in collaboration with regional and place-based teams (April 2024)
- Mobilisation of DPP provider – NEL & place based teams (July 2023)
- Alignment with APC outpatient programme to implement GIRFT recommendations and PIFU (Q3 23/24)
- Evaluation of 23.24 Digital structured education mobilised (February 2023)
- Rollout of LTC indicators (led contractually by primary care) – impacting on benefits (December 2023)
- Establishment of diabetes psychiatry resource across NEL (April 2024)
- Establish local action plans to drive improved uptake of structured education services including healthy living national programme (June 2023)
- DPP CEG health inequalities tool rolled out across NE (May 2023)
- Central Referrals programme for DPP rolled out across (May 2023)
- Group consultation pilot concluded, and evaluation report produced –April 2023
- COVID recovery projects delivered – across places (October 2023)
- Full recurrently funded DISN provision across NEL via WF place (August 2023)
- Full recurrently funded MDFT provision across NEL via TH & WF place – (December 2023)
- Launch of diabetes workforce education programme (May 2023)
- Type 2 pathway review complete and QI products undertaken – Newham (April 2023)

Further transformation to be planned in this area:

Over the next two years

- Establishment of TIED services across NEL
- Type 1 services framework implemented across NEL
- Establishment of group consultation model across NEL

Over years three to five

- NEL wide resident appropriate options for patient education
- Integration with related clinical networks – e.g., CVD, renal

Programme funding:

- SDF funding NEL & place-based programmes of work (this is does not include diabetes local budgets e.g.,

in addition to BAU . Contracted recurrent funding

- SDF funding
  - 22.23 1.7m
  - 23.34 126k (90% reduction)

Leadership and governance arrangements:

- Programme Director, Deputy Programme Director, Interim Senior programme manager, Project Manager, Clinical leadership (acute & PC) at workstream level
- Working groups established – NDPP, LCD, diabetic foot
- Working groups planned – Type 1, Structured education
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External assurance is via the Regional Diabetes Network and national programme

Key delivery risks currently being mitigated:

- ICB workforce capacity to support matrix working
- Financial reduction in NHS SDF funding in 23.24
- On-going clinical leadership at NEL and place
- Delivery against key programme areas as outlined in LTP commitments and planning guidance

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

Transformation in NEL

North East London Health & Care Partnership

Neurosciences Programme / NEL / Archna Mathur, Director of Performance & Assurance, NHS NEL- archnamathur@nhs.net

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

April 2024:

- 90% of people presenting with symptoms of Transient Ischaemic Attack will have access 7 days a week to stroke professionals who can provide specialist assessment and treatment within 24 hours of symptom onset thus preventing long term disability
- 10% of eligible stroke admissions will have consistent 24/7 access to mechanical thrombectomy to reduce the impact of stroke
- All residents who experience a neurological condition will have equitable access to high quality specialist rehabilitation across the pathway of care (acute, bedded and community) to maximise outcomes for each individual

April 2026:

- All residents with a neurological condition will have rapid access to specialist care and advice to empower them to manage their own condition effectively and avoid repeated acute admissions
- Residents who require acute admission will have rapid access to high quality, specialist care
- All residents with a neurological condition will have access to the full range of specialist rehabilitation closer to home to maximise individual potential and reduce complications

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

- By reducing unwarranted variation in access to specialist assessment and treatment within 24 hours of symptom onset for NEL residents with TIA which currently ranges between 40% for BHR residents to 92% for City and Hackney residents
- By ensuring NEL residents (up to 10% of all stroke admissions) can have consistent access to 24/7 mechanical thrombectomy for stroke within sector (currently only 5.8% receive this across BHR and 6.8% across Tower Hamlets, Newham, Waltham Forest and City and Hackney)
- By reducing unwarranted variation in :
  - access to hyper-acute rehabilitation for trauma patients (currently none available),
  - timely access to specialist inpatient neuro rehabilitation for people with tracheostomies (currently none available in sector)
  - level 2b bedded rehab (currently only 7 beds within the sector) so 27% of NEL residents wait more than 14 days in an acute setting to be assessed and 22% wait more than 42 days from assessment to transfer to specialist bedded rehab
  - access to specialist community rehab for people with stroke and neuro conditions (only 30% of eligible stroke survivors are discharged with early supported discharge; one place does not provide community neuro rehab; in other places there are significant waits of up to 5 weeks for intervention)

Key programme features and milestones:

- *Prevention* – improve detection and management of atrial fibrillation delivered through the LTC outcomes framework by Q2 23/24
  - Co-produce 7 day TIA service with residents so that 90% of people with TIA symptoms receive assessment and treatment within 24 hours of first presentation to a healthcare professional by September 2023
- *Acute care* – implement consistent 24/7 mechanical thrombectomy service by July 2023 so that 10% of stroke admissions receive this intervention and improve quality of care so that 90% of patients experience door to groin time at or under 90 minutes resulting in better outcomes (time is brain) by December 2023
  - establish 8 Rapid Access Acute Rehabilitation beds at the Royal London to improve patient outcomes and experience and reduce overall length of hospital stay by May 2023
  - Alignment with APC outpatient programme to implement GIRFT recommendations and PIFU (Q3 23/24)
- *Rehabilitation* –co-produce rehabilitation services that meet residents needs and ensure care is received in the right place at the right time (tracheostomy beds at RNRU by March 2024; level 2b beds by March 2024; community stroke and neuro rehab services by September 2023)

Further transformation to be planned in this area:

Over the next two years

- NEL vocational rehabilitation service
- Improve acute stroke standards and flow across the stroke pathway

Over years three to five

- NEL spasticity service
- Rehabilitation facilities for people with complex cognitive and behavioural challenges and disorders of consciousness

Programme funding:

- Stroke funding from NHS England:
  - £88,000 – community rehabilitation
  - £165,000 – programme clinical leadership

Leadership and governance arrangements:

- Programme Director, Deputy LTC Programme Director, informal clinical leadership, Senior Programme Manager
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External assurance is via the North London Respiratory Clinical Network, regional and national programme

Key delivery risks currently being mitigated:

- History and culture within teams and clinicians driving resistance to change
- Regional neurosciences mandated clinical networks not aligned to developing local priorities
- Lack of delivery against key programme areas as outlined in LTP commitments and planning guidance due to:
  - workforce availability to staff new clinical teams
  - ICB workforce capacity to support matrix workin
  - NEL and place clinical leadership

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Renal Clinical Network / NEL / SRO: Charlotte Stone, Programme Director. NHS NEL - charlotte.stone14@nhs.net

The benefits that North East London residents will experience by April [2024] and April [2031]:

April 2024:

- Prevent residents of NEL from Chronic Kidney Disease and prevent the progression of the disease – this is being done via:
  - Improved access to specialist CKD intervention clinics for all NEL residents. By 2024 virtual CKD Clinics will be available across NEL with the service in BHR due to go live.
  - Roll out of NEL/London Kidney Network CKD Pathways and roll out of SGLT2i guidance
- "Transplant First" - Develop model in AKCC (Advanced Kidney Care Clinic) to promote "Transplant first" as primary option for patients with AKCC and support Getting It Right First Time recommendation to increase pre-emptive transplantation – currently not meeting the target London average of 35% with NEL at 32%.
- Home therapies – Improved access to home therapies - by 2024 there will be an Independent Therapies Centre at Mile End Hospital (and a young person's unit) and by 2024 a Mosque dialysis Unit will be in place. Currently achieving target of 20% dialysis patients on home therapy - 78 patients either having haemodialysis at home, or in training to do so, with plans to increase this number.
- Improve peritoneal dialysis rates – currently meeting target of peritoneal dialysis with 251 patients on peritoneal dialysis, with plans to exceed the target.
- Care closer to home - Where Transplant or Home Therapy cannot be achieved for patients, to ensure that their care is as close to their home as possible including earlier engagement via outreach advanced kidney care clinics
- Improved outcomes of renal risk factors eg ACR and hypertension – via LTC outcomes framework

- By 31/32:
  - Specialise services proactively working as part of end to end pathway transformation approach, with a aim to reduce residents attending specialise service with preventable conditions by improving prevention programmes in NEL and halting the progression on LTCs
  - Maximise patient dialysing at home - 496 patients on home therapies by 31/32 (target of 28% of patients on home therapies by 2032).
  - Maximise patients being transplanted - 280 transplant operations completed in 31/32

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

- Through the development of the home-away-from-home haemodialysis unit at Mile End Hospital and Mosque Dialysis Unit – this will give access to home haemodialysis to those who do not live in suitable properties.
- Developing a plan to address the recommendations outlined in the Health Equity Audit completed by the London Kidney Network
- East London has a higher than expected number of patients with CKD stage 3-5 (given its population age-structure).Through the roll out of virtual Chronic Kidney Disease (CKD) Clinics in BHR by Q1 23/24 – thereby reducing variation and inequalities as BHR is currently an outlier
- NEL has higher than average did not attend (DNAs) for renal outpatient transformation which has been deprivation, working with the London Kidney Network we're working to improve health literacy and improving communication with residnets

Key programme features and milestones:

- Prevention: Implementation of the virtual CKD clinics in BHR using a single ICS specification (Q1 23/24)
- Renal Network: Develop a NEL Renal Strategy (including incorporating the NEL Health Equity plan) (Q2 23/24)
- Alignment with APC outpatient programme to implement GIRFT recommendations and PIFU (Q3 23/24)
- Dialysis & Home Therapies: Establishment of 2 home-from-home haemodialysis stations in the East London Mosque (Q3 23/24)
- Dialysis & Home Therapies: Independent Therapies Centre (ITC) at Mile End Hospital (building complete Q3 23/24)
- Prevention: Roll out of SGLT2i guidance (including development of guidance and education) (Q1 23/24)
- Prevention: Roll out of the London Kidney Network/NEL Chronic Kidney Disease Pathway (Q2 23/24)
- Roll out of the LTC outcomes framework with CKD indicators (Q2 23/24)
- Completion of Pilot in BHR – early identification of people with raised uACR. Evaluation is in Q1 22/23

Further transformation to be planned in this area:

Over the next two years

- Roll out of CKD dashboard and Learning health system approach to drive improvement in CKD identification and care
- Pharmacist led CKD desktop reviews to optimise medications including ACEi/ARB, SGLT2is and Statins
- Consultant led case based discussions sessions for education to facilitate transfer of expertise to frontline primary care
- Personalisation including BP self-monitoring, lifestyle and symptom monitoring/management
- Recall support for BP monitoring, bloods, uACR testing and annual reviews

Over years three to five

- Scoping for potential Dialysis hub in Hackney
- Community case finding in Places of Congregation with Point of care testing and BP checks

Programme funding:

- Funding of Independent Therapies Unit via Barts Charity
- Local place transformation funding

Leadership and governance arrangements:

- Clinical leads (primary and secondary care), senior programme manager (WTE 0.5) , deputy LTC programme director and programme director.
- NEL Renal Clinical network
- Working groups – Dialysis & home therapies, transplantation, prevention
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External assurance is via the London Kidney Network, NHS England regional and national teams.

Key delivery risks currently being mitigated:

- Capital funding for machines required for the Independent therapies centre
- On-going clinical leadership at NEL and place
- Resourcing the Renal Programme – Frailty/Supportive care on hold pending additional resource

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Respiratory Clinical Network Programme / NHS NEL / Gary Dark, Programme Manager, NHS NEL - gary.dark1@nhs.net & Paul Pfeffer, Respiratory Consultant, Bart's Health - paul.pfeffer1@nhs.net

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

April 2024

- Improved access for local people to Early & Accurate Diagnosis of respiratory conditions delivered through Primary Care Hublets available in all 7 Places (currently provided in 3). This will reduce the inequality of waiting times and act as a catalyst to increasing the % of local people thar require a diagnostic test within 6 weeks in line with the national ambition of 95% by March 2025. For local people this will ensure earlier access to care and treatment and help plan ahead.
- Access to Virtual Wards Acute Respiratory Infection (ARI) available to local people in every NEL 'place' in time for winter 2023/24 (currently provided in 2 Places). This will facilitate care for local people in their own homes.
- Collaborative care planning to support holistic assessment of need and agree individual care plans. These plans will ensure that NEL residents live the life they want to live based on what is important to them.
- Improved access to pulmonary rehabilitation (PR) delivered through an increase in capacity& resources and tailored information. Ensuing the local population benefit from increased respiratory muscular strength (Subject to regional PR funding).
- People living with respiratory conditions can have more confidence that a wide range of healthcare staff understand how to manage respiratory disease delivered through respiratory workforce education programme. For the local population, this will improve best value (more cost-effective prescribing and less waste of medicine) and reduced harm.

April 2025/26

- 2025: Delegated responsibility for specialised commissioned services to NEL ICB will allow the local population a greater voice on how the services they use can be improved and how linkages of care across the end to end pathway can be improved (which will improve patient outcomes).
- 026: Develop a new end-to-end clinical pathway for COPD leading to Lung Volume Reduction Surgery where appropriate. This will for the local make lung function more effective and improve breathing ability and quality of life
- 2026:Pulmonary Rehab
  - Available to patients with all chronic lung conditions, including complex breathlessness, available in a mix of provision i.e. F2f, virtual.
  - Increasing the % of the eligible people who are referred from 52% to 90%.
  - Increasing the % of the people completing a PR course from 42% to 80%.
  - Increasing the % of PR service users starting a course in 90 days from 54% to 90%.
  - n/b patients participating in PR will benefit from an improved health related quality of life, improved exercise capacity, increase respiratory muscular strength and improved exertional dyspnoea, (Subject to regional PR funding)

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

- By April 2023 completed mapping of providers of respiratory care across NEL. This will comprehensively identify regional inequalities in provision, and the gap between required and available provision.
- From April 2023 use of a Severe Asthma Enhanced Patient Identification Scheme to identify local residents who might benefit from specialist care but have not requested referral from GP (currently under 20% of patients eligible for severe asthma biologics are receiving in NEL leading to thousands of preventable exacerbations / A&E attendances / hospitalisations).
- By winter 2023/24 all 'Places' will have accredited providers (Hublets) of Diagnostic Spirometry and FeNO to reduce inequalities across NEL (currently available in 3 Places with none-to-little provision in remaining 4 Places) to be followed by educational videos in all local languages to explain the why & how of respiratory diagnostic testing.
- By April 2024/25 Pulmonary Rehab (including patient education materials) will be available in a minimum of 5 local languages as a digital resources (currently limited availability for non-English speaking patients), for all common respiratory conditions (primarily currently available for patients with COPD). Content for this digital resource will be developed and co-produced by the 3rd sector and those with lived with experiences. Across the NEL footprint English spoken as a 1st language can be as low as 65% (Cencus 2021) **(Subject to regional PR funding)** .2 S021).
- By April 2025/26 new services for vulnerable NEL residents with no fixed abode, to try to bring proactive care with better diagnostics and immediate management to these patients

Key programme features and milestones:

- PR accreditation for all providers (Between 2023-2026/ HUH 2023). The local population with lived with experiences will complete an engagement exercise, to help improve current clinical pathways. **Subject to regional PR funding**
- New Digital PR DHI with shared-working between 'Places' (co-production beginning March 2023 with potential capacity for circa 250 extra participants a year).
- Alignment with APC outpatient programme to implement GIRFT recommendations and PIFU (Q2 23/24)
- New LTC framework and new inhaler formulary to incentivise respiratory diagnostics and personalised inhaler prescriptions to optimise care and reduce carbon costs Q2 23-24.
- Diagnostic hublets rolled out in all 7 NEL 'Places' (Q1 2023-24)
- ARI VWs rolled out in all 7 NEL 'Places' ('Winter 23/24).
- Ensure equity in access for vulnerable cohorts homeless and those suffering from mental health illness (September 2023 onwards). Colleagues from the 3rd sector and local people with lived with experiences will support in the co production of new access routes. **Subject to regional PR funding**

Further transformation to be planned in this area:

- Over the next two years
  - Severe Asthma Enhanced Patient Identification Scheme
  - New ILD, Home Ventilation & Breathlessness MDT networks
- Over years three to five
  - New pathway for Enhanced Patient Identification for LVRS
  - PR services for complex breathlessness
  - new services for vulnerable NEL pts with no fixed abode

Programme funding:

- Non-recurrent funding for Pulmonary Rehab £480,000 per annum. No current commitments for funding for 2023-24
- Non recurrent funding for ARTP £25,000 per annum. No current commitments for funding 2023-24
- All other activity to be delivered within existing budgets.

Leadership and governance arrangements:

- Acute clinical leadership at network level, Programme Directors, Deputy LTC programme director, senior programme manager (WTE 0.2), deputy programme manager (WTE 0.5)
- NEL respiratory Clinical Network
- Working groups established – PR, Oxygen, PR, Hublets & medicines optimisation.
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External assurance is via the North London Respiratory Clinical Network, regional and national programme

Key delivery risks currently being mitigated:

- Funding - concerns around Hublet funding and sustainability of current non-recurrent funding for PR, VWs etc.
- Limited physical site-capacity for some specialist services potentially delaying specialist treatments.
- ICB workforce capacity to support matrix working
- On-going clinical leadership at NEL and place

Alignment to the integrated care strategy:

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

North East London Health & Care Partnership

NEL ICB HIV Clinical Network Programme SRO: Charlotte Stone (charlotte.stone14@nhs.net)

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

- April 2024
  - 90% of those who attend an Emergency Department (ED) will be tested for HIV.
  - Local people will experience more follow up care with investment in a community led peer programme with an aim to reduce by 70% the number of eligible patients that are lost to care/failed by care. This follow up care will include HIV testing, councelling, mentoring, group support, assurance and information and advice.
  - Reduced preventable deaths from HIV related causes increasing pathway resilience and optimising opportunities for joint working with the HIV community and ICS partners.
- More open conversations to raise the awareness, challenge unconscious bias and reduce sigma associated with HIV by working with local communities and charities, and working with people living with HIV.
  - Working with fast-track cities to train people living with HIV to become community ambassadors, and work with different parts of the health and social care sector to increase knowledge of HIV, with the aim to provide trauma-informed care based on the principles of safety, trust, choice, collaboration, empowerment and cultural competence.

- April 2026:
  - Delegated responsibility for specialised commissioned services to NEL ICB will allow local residents a greater voice on how the services and linkages of care across the end to end pathway can be improved (which will improve patient outcomes). This will be achieved by having a resident's voice embedded within the governance structure.
  - An 80% reduction in new HIV infections (based on 2022 new infection rates).
  - A 50% reduction in of patients diagnosed with AIDS within 3 months of diagnosis.
  - A 50% reduction in the number of deaths from HIV/AIDS.

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

- Currently the percentage of those that receives a HIV blood test varies (from 4% - 56%) depending on which acute hospital they visit. We are proactively with NEL trust, charities and local communities looking to improve pathways and awareness for opt out testing in AD's for HIV. With the aim of ensuring 70% of all appropriate attendees at ED get a HIV test by the end of Q1 2023/24 and 90% of all appropriate attendees at ED get a HIV test by the end of Q2 2023/24.
- A number of NEL 'Places have been identified as having a "very high" number of HIV diagnoses. We are working with community HIV services to improve access and commission partnership initiatives across the health/3rd sector and local authorities.
- Increase knowledge and access to sexual health information (for example STI, HIV and mpox) as well as HIV and STI testing amongst GBMSM and Bangladeshi GBMSM in 7 NEL 'Places'. This will be achieved via increased use and enhancement of AI chat bot technology and enhanced website functionality using latest design and development approaches.

Key programme features and milestones:

- All acute hospitals will provide blood tests to 70% of those who attend ED (Q1 2023/2024).
- All acute hospitals will provide blood tests to 90% of those who attend ED (Q2 2023/2024).
- Implementation of automated HIV blood requests at all NEL acute hospitals (Q1 2023/2024).
- To work in partnership with the HIV community, local charities and ICS stakeholders to co-design a community led peer intervention programme for patients that are lost to care/failed by care (March 2023).
- Work with fast-track cities, local charities listen and those within the local population that have lived with experiences to understand how we can co-design initiatives that moves towards trauma informed care across the pathway (medium term strategy 2023 –2025).

Further transformation to be planned in this area:

- Over the next two years:
- Business case to secure recurrent funding for HIV opt out testing in ED.
- Working with fast-track cities and local charities to improve education of our workforce and reduce stigma

Programme funding:

- HIV- (£1.1m)
  - 65% pathology costs / 35% end to end pathway improvements.

Leadership and governance arrangements:

- Programme Director, Clinical leadership across NEL for key programmes of work across acute setting, no overarching clinical lead. Approx 0.2WTE senior programme manager
- Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established) and place governance
- External assurance undertaken by regional and national specialised service programme

Key delivery risks currently being mitigated:

- Variation in the percentage of HIV blood tests completed in ED's – escalation meetings arranged with acute hospitals.
- The extent of key programme delivery and benefits for residents will be dependent on London regional funding for 2023-24 & 2023-25
- ICB workforce capacity to support matrix working

Alignment to the integrated care strategy:

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

North East London Health & Care Partnership

NEL ICB Hepatitis & Liver Programme SRO Charlotte Stone (charlotte.stone14@nhs.net)

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

- April 2024 – utilising the pillars contained within Roadmap to eliminating HCV in London
- ➢ 90% of residents who attend an Emergency Department (ED) will be tested for HBV and HCV (unless they opt out). The benefit to the local people will be that they will not live a life of not being diagnosed, which may have greater health implications in the future.
- The local population will experience more follow up care with investment in a community led peer programme with an aim to reduce by 70% the number of eligible patients that are lost to care/failed by care. This follow up care will include regular testing, counselling, mentoring, group support, assurance and information and advice.
- ➢ Reduced waiting times for local people requiring a first clinical intervention across NEL by increasing resilience and optimising opportunities for joint working. This will support early treatment and improve quality of life for local people.
- ➢ Co design awareness initiatives to reduce the stigma associated with hepatitis. This will be achieved by working with local communities, charities and people with lived with experiences. This will improve local people's lives as health professionals will become more knowledgeable, the general public's attitude and behaviours should change for the better, which should provide a better quality of life for local people with lived with experiences.
- Some disadvantaged and vulnerable groups are at risk of HCV. We plan to partner with homeless assessment centres and local communities to provide reach and treat support for local people who maybe more susceptible to hepatitis and liver disease. For local people with lived with experiences, this will ensure earlier access to care and treatment and support for planning ahead.

- April 2026:
- Delegated responsibility for specialised commissioned services to NEL ICB will allow local people a greater voice on how the services and linkages of care across the end to end pathway can be improved (which will improve patient outcomes). This will be achieved by ensuring local peoples voices are embedded in the governance structure.
- ➢ To achieve micro elimination of HCV across NEL (2025).
- ➢ Improved access to diagnostics and increase local prevention programmes by aligning with the British Liver Trust optimal pathway. This will support the reduction in the growth rate of liver disease (currently 20%).
- ➢ Access to HBV clinical services will be increased, offering patients care closer to home.
- ➢ Reduced waiting times for patients with a HBV positive diagnosis will reduce the likelihood of patients developing acute liver disease .

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

- The Hepatitis C Trust has identified that disadvantaged and vulnerable groups are disproportionally at risk of Hepatitis C. These groups include local people who are homeless, local people who inject drugs but are not in touch with treatment services and undocumented migrants and sex workers. Through partnership working with health and social care providers, local communities and those with lived with experiences, we will look to open the conversation regarding stigma. Reducing stigma will help increase the knowledge of health professionals, the general public's attitude and behaviours should change for the better, which should provide a better quality of life for local people with lived with experiences
- NEL has a 20% growth rate in liver disease year on year. This is directly linked to deprivation, obesity and excess alcohol consumption. We aim to increase prevention and halt the progression of liver disease by working towards British Liver Trust optimal pathway.

Key programme features and milestones:

HBV & HCV

- All acute hospitals will provide blood tests to 70% of those who attend ED (Q1 2023/2024).
- All acute hospitals will provide blood tests to 90% of those who attend ED (Q2 2023/2024).
- Recruitment of a community HCV/HBV nurse to enhance the current community programme (Q1 2023/2024).
- Implementation of automated HCV/HBV blood requests at all NEL acute hospitals (Q1 2023/2024)
- **North London Liver Disease Network**
- To co-design with NEL/regional colleagues and local people the scope and operating model for the North London Liver Disease Network (Q4 2022/2024).
- Approval of the operating model and funding by North London Programme Board and National specialise service team (April 2023).
- Agree across three North London ICS prioritises for liver disease for the remainder of 2023/24 (May 2023).

Further transformation to be planned in this area:

- **HBV&HCV**
- Business case to secure recurrent funding for HBV & HCV opt out testing in ED.

North London Liver Disease Network

- The agreement of outcome-based metrics to demonstrate the clinical value of the network (early detection rates for liver disease, the prevention of cirrhosis, reduced re-admission rates for patients with decompensated liver disease).

Programme funding:

- Funding provided via the Hepatitis ODN and via the A&E opt out testing - £767,538
- ODN funding 159,000

Leadership and governance arrangements:

- Programme Director, interim clinical ceadership being provide by ODN, senior programme manager (0.2WTE)
- North London Liver Clinical network (to be established 31st March 2023) which feeds into the Internal assurance is via the APC specialised service, LTC (NEL LTC programme board being established)
- External assurance undertaken by regional and national specialised service programme

Key delivery risks currently being mitigated:

- Variation in the percentage of HCV & HBV blood tests completed in ED's – escalation meetings arranged with acute hospitals.
- The extent of HCV/HBV key programme delivery and benefits for residents will be dependent on London regional funding for 2023/2024
- ICB workforce capacity to support matrix working
- Clinical leadership

Alignment to the integrated care strategy:

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

North East London Health & Care Partnership

NEL ICB Haemoglobinopathies Clinical Network Programme SROs: : Archna Mathur (archnamathur@nhs.net) and Charlotte Stone (charlotte.stone14@nhs.net)

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

April 2024

- Local people with sickle cell will receive appropriate analgesia and other pain management measures (ideally within 30 minutes) when attending any acute A&E in NEL
- Local people will expertise reduced variation across NEL within Specialist Haemoglobinopathy Team services, as we're working with teams to achieve to optimal pathways for diagnosis and management of sickle cell and thalassaemia.
- Residents will have timely access to multi-disciplinary team to support delivery of trauma-informed care based on the principles of safety, trust, choice, collaboration, empowerment and cultural competence.
- Local people will feel supported with an increase in awareness of sickle cell among healthcare professionals, as highlighted in No One's Listening report. For the local population, this will improve best value (more cost-effective prescribing and less waste of medicine) and reduced harm
- 84 children and young adults will have opportunity to be mentored by qualified Sickle Cell Society mentors to feel more empowered about their care, support health literacy and support them through transition between young adult and adult service

- April 2026:
- Delegated responsibility for specialised commissioned services to NEL ICB will allow the local population a greater voice on how the services and linkages of care across the end to end pathway can be improved (which will improve patient outcomes).This will be achieved by having a resident's voice embedded within the governance structure.
- Reduced treatment delays and/or reduce hospital admissions due to faster referral pathways for patients with complex disease (or needing high-cost interventions)
- Reducing duplication and saying their 'story' more than once by improving IT solutions in the urgent care pathway so every healthcare practioner can access the same care plan

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

- Barking and Dagenham have the highest rates of people with sickle cell disease. We will work with Specialist Haemoglobinopathy Team (SHT) at BHRUT to increase resilience and improve outreach to support local people.
- Within the age group of 10-24yrs, NEL has a rate of infection of between 400-700 per 100,000 for sickle cell disease. We will work with the Sickle Cell Society and ICS partners to extend the current mentoring programme to all eligible local residents within the10-24 yrs cohort (currently only delivered in City & Hackney) across the 7 'Places' to ensure equity of access.
- Work with local people with lived experience and local communities to co-design educational material to reduce stigma and provider greater opportunity of early diagnosis (including at birth), with a key focus on areas of deprivation - with local people living in the most deprived areas of NEL having almost 75% higher rates than areas in the second most deprived quintile. To note NEL has the highest level of deprivation of any London ICB.
- The Sickle Cell Society has identified sickle cell as a condition that predominantly affects people with African or Caribbean heritage and patients, the no one listening report highlighted racial inequalities in care across England, we are working with healthcare professionals to stop racists behaviours and challenge unconscious bias to reduce inequalities

Key programme features and milestones:

New programme – started in February 2023 and working with the specialise service Haemoglobinopathies Coordinating Centre (HCC)

The development of an ICB governance structure , that supports the HCC and provides assurance for the delegation of service from the London region (April 2023).

The delivery of a 'deep dive' to enable the HCC, the ICB and other key stakeholders understand and agree on the priorities for the next 12 months (April 2023).

Development of Trust specific business cases for accessing MedTech funding for automated exchange. This will reduce inequalities and support elective and emergency access to auto exchange 24/7. (Q4 2022/23).

- Implementation of recommendations from the APPG sickle cell report (No One is Listening) to ensure improved patient experiences. (Q2 2023/24)
- The increase of partnership working with pharmacy leads, the London red cell pharmacy group and Trusts to access new drugs (Q3 2023/24).
- Standardisation of service delivery. (Q4 2023/24).

Further transformation to be planned in this area:

- Over the next two years:
  - Address how workforce shortfalls can be mitigated against.
  - Improved data reporting of service users with haemoglobinopathies (currently only 50-70% of patients are recorded).
  - Develop a strategy to prevent acute exacerbations and end organ complications
  - Establish a learning and development framework. This will enable all healthcare professionals to be up-skilled in the management of sickle cell disease.

Programme funding:

- Funding via HCC and direct to trusts for programmes

Leadership and governance arrangements:

- Programme Director, 0.3WTE of a programme manager. Interim clinical leadership being provided with support of HCC, while we secure funding
- Internal assurance is via the specialise service and LTC (NEL LTC programme board being established) governance
- NEL working with HCC's to support service delivery and improving linages of care across the end to end pathway
- External governance regional and national programmes

Key delivery risks currently being mitigated:

- Workforce capacity to support the standardisation of the SHT at Queens, ICB, LTC and Specialised Services directorate are providing additional resource.
- The level of funding received from the London region is insufficient to meet the service specification. A services 'deep dive' will help to better understand the challenges.
- ICB workforce capacity to support matrix working

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Prevention/Prohab / Barking and Dagenham, Havering, and Redbridge place partnerships / Jeremy Kidd, Deputy Director of LTC, NHS NEL -jeremy.kidd1@nhs.net

The benefits that Barking, Havering & Redbridge [BHR] residents will experience by April 2024 and 2029:

By 2024

- Population-level approaches to reducing cardiovascular disease via targeted themes and campaigns
- Linking population approaches to individual approaches in primary care
- Improve management of disease-specific cardiovascular disease to reduce level of risk and increase early identification of condition-specific disease
- Improve effective early management of condition-specific cardiovascular disease
- Improved management of **CVD risk factors** eg ACR and hypertension – via LTC outcomes framework (thresholds tbc)

By 2029

- Leverage analytics/algorithms and visualisation tools to understand, track and report on population activity and measure improvements
- Improved coordination between population approaches and individual approaches in reducing risk, increasing early identification and effective management of those
- Residents know who, where, how and when to access -services/teams, flexed to the needs of place. The culture of good/better health will become the norm rather than waiting until ill health presents before they receive appropriate care
- Greater peer led community support and engagement to enable self-care and lower acute care utilisation, reducing non-elective [NEL] admissions/readmissions & A&E attendances for the major LTCs
- Improve the number of people with high blood pressure are diagnosed; improve the total number of people already diagnosed with high blood pressure are treated to target as per NICE guidelines

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

- Understanding the whole risk reduction agenda from cradle to grave better in order to put in place planned strategies to engage people to own their own health, to attain good or better health at any stage of their lives, with or without identified CVD [prohab].
- Maximising opportunities to identify CVD conditions early, initiate treatment promptly and refer swiftly if indicated.
- Understanding and removing any practical barriers that prevent some residents from seeking access to health services, and participating in population or individual interventions
- Improving the quality of patient-health professional contacts in partnership working to support individuals in making good decisions regarding their health/their families' health to motivate people towards good/better health at all stages of their life.
- Strengthen the role of voluntary, charitable and community sector providers in working with individuals/families and remove any constraints and barriers to that happening.

Key programme features and milestones:

- The role of Place from 2023 onwards in ensuring delivery of end to end pathways and the importance of promoting good/better health [prohab] at all stages of a person's life
- Developing a completely different approach to health and illness [rather than the traditional patriarchal approach], promoting ownership of an individual's health and good health throughout life, so working holistically in partnership with individuals rather than mainly treating illness.
- Continuing to deliver the projects currently underway looking at early identification and treatment.
- Much greater emphasis on identifying individuals potentially at risk at a much earlier age, using whatever means are more appropriate for our local population
- Specific cohorts of people with raised/borderline [estimated ~63K in BHR] hypertension and/or chronic kidney disease [CKD] , people requiring potential weight management needs [rising numbers in Type 2 diabetes secondary to obesity – now presenting in children of primary school age]

Further transformation to be planned in this area:

Over the next two to five years

- Development of CVD dashboards that provide actionable insights
- Scoping opportunities for standardising access, delivering care, supporting ownership of one's own health, promoting good/ better health not just treating illness, from cradle to grave holistically
- Continue implementing the new model of co-production

Programme funding:

- Identifying current services and roles already funded and in place, and 'repurposing' the skills and experience of individuals identified.
- Unknown at present for any identified gaps but potentially aiming to provide new model within existing envelop of monies from different providers

Leadership and governance arrangements:

- Place-based partnership actively participating in the newly formed PRIME working group [formerly the EIFR Working Group]
- NEL Clinical Networks: Cardiovascular Clinical Network; Renal Clinical Network
- Pan-London [Regional] Renal Network

Key delivery risks currently not being mitigated:

- CVD risk assessment using a tool that is **not** relevant to a large majority of our potential 'at risk' local population
- Delay in developing a new generic Prohab team that could provide access to many more individuals with overt CVD/respiratory conditions [currently accessing condition-specific rehab programmes with limited spaces available], as well as 'prehab' for individuals seeking to optimise their health such as people seeking weight management support, hypertension etc
- Understanding of whole-system-change and the opportunity to be really innovative could suppress meaningful transformation plans for this very important workstream

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Diabetes / Barking and Dagenham, Havering, and Redbridge place partnerships / Jeremy Kidd, Deputy Director of LTC, NHS NEL -jeremy.kidd1@nhs.net

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

By 2024

- The number of BHR residents with diabetes (T2) receiving eight care processes (8CP) in primary care increase in number (70%+); the quality of process checks improves allowing both better health and early referral when necessary (e.g. foot health or renal)
- CYP diagnosed with diabetes (T1) are supported by a Transition service (ages 12-25) that equips them for later-life and is supported by new capabilities of Insulin Pumps and Continuous Glucose Monitoring (CGM) – which are also for adult residents
- PCN leadership at Place establishes community links with residents (LA supported and via charities, faith groups and schools) that begin to address false beliefs about diabetes and promotes life-style change. This supports reduction in the at-risk of diabetes cohort (NDH) and pilots capability around diabetes remission.
- Review of pathway and referral thresholds increases workforce empowerment and resident access.

By 2026

- Improved health and wellbeing for residents, particularly those with long term conditions
- The level of 8CP delivery is high (80%+) and stable; year-on-year improvements in numbers controlled (target 70%+); QI improvements have led to improved referrals and starting to reduce care required for complications (e.g. amputations)
- CYP capacity at acute improved by Transition services whose first 'graduates' are expert-users in Pump and CGM technology which reduces hospital care and improves quality of life; advice to pregnant woman with diabetes, as well as those planning pregnancy, reduces complications including avoidable birth defects
- Place-based networks for diabetes are maturing and providing contact-points for local residents either who have diabetes, are concerned about diabetes for themselves or friends/family or generally want to live healthier.
- New capabilities of Insulin Pumps and CGM are present in acute and community; this improves quality of life, employment options and reduces emergency care; workforce skills are enhanced and NEL starts be known as a great place to deliver diabetes care
- Residents know where, when and how to access the care they need for the assessment and management of long-term conditions; no longer have to 'feel worse' to receive care
- Residents with health conditions will be assessed, identified and provided with condition management as early as possible.

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

- Primary care delivery of diabetes care was significantly impacted by Covid-19; the evidence shows that in London that residents with diabetes but who did not get Covid-19 have experienced an increased death-rate. In addition, deprivation, ethnicity and the greater incidence of key workers in East London increases the risk to residents with diabetes.
- The current service gap of no CYP Transition service was highlighted by a GIRFT peer-review of BHRUT and contrasts with BH Trust which was funded to pilot Transition services. Similarly, offering Insulin Pumps in BHR will match BHRUT to BH capabilities, while a comprehensive offer of a CGM capability across NEL has potential to radically improve the lives of residents of working-age who suffer poor diabetic control.
- Place-based community mobilisation around living with or avoiding diabetes will be critical in arresting the current growth of diabetes trajectories which will otherwise undercut our residents economic prosperity and our health economy; this work needs to be community and culturally informed.

Key programme features and milestones:

- Establish Governance for 2023-24 and forward, including linkage to Place
- Primary care (Q1-Q4)
  - Delivery of LTC LIS and transition to LTC Outcomes Framework
  - Develop PCN diabetes leadership and their mobilisation of Place networks, Training and QI programmes
  - Review Injectables (Q2)
- Business cases; for Transition, Insulin Pumps, CGM and Community Redesign (Q1)
- Full system diabetes pathway review and criteria
- Secondary
  - Recruit lead consultant for Transition plus other staff for team (Q3)
  - Plan Pumps and CGM programme with Community Care (Q2)
  - Start Transition, Pumps and CGM (earliest Q3 or by Q4)
  - Develop a NEL CVD Strategy (Q2 23/24), Start MH (T1) service (Q2)
- Community
  - Review BHR services to equalise offer (Q1-Q3)
  - Move to new delivery model (Q4 and developed through 2024-25)
- Other; work with enablers, e.g. CEPN, CEG etc.

Further transformation to be planned in this area:

Over next two to five years

- Patient Education; develop resident appropriate options and healthy-living programmes that resident want to complete
- Integration with related schemes as they develop e.g. Obesity, Hypertension, Renal
- Providing support to enable independent living for as long as possible via the development of integrated teams

Programme funding*:

Currently costed scheme,

* Sources of funding to be identified

- Transition service* £365k and Primary care; £1,800k

Schemes being estimated

- Pumps, CGM* £600k and Community care redesign* (too early)

Leadership and governance arrangements:

- Level 1 – BHR LTC Board (or its successor)
- Level 2 – NEL Diabetes Partnership Board
- Level 3 (operational) – Diabetes Operational Working Group (or its successor)

Success will need co-ordination or contract management with:

- Networks; NHSE London, Primary Care (local and London), CVD, Obesity, Renal, Hypertension, UCLP
- Partners; BHRUT, NELFT, PCNs, Prescribing
- Other providers; Xyla, CEG, Oviva, Federations, et al.

Key delivery risks currently being mitigated:

- Funding: low availability or funds will supress transformation plans; mitigate through work understanding whole-system-impact and efficiencies of
- Workforce: attraction and retention could limit development; mitigate through inter-provider work and skills transfer (e.g. pumps) plus training (CEPN)

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Cardiology (HFrEF & HFpEF)–/ Barking and Dagenham, Havering, and Redbridge place partnerships / Jeremy Kidd, Deputy Director of LTC, NHS NEL -jeremy.kidd1@nhs.net

The benefits that Barking, Havering and Redbridge residents will experience by April 2024 and 2029:

By 2024
- Reducing variation in practice for people with **heart failure**, improving care and outcomes for patients who access acute, community and primary care
- Delivering good links via integration between community and acute via multidisciplinary team (**MDT)** meetings
- Improve **cardiac rehabilitation (CR)** to include cancer pre-rehabilitation and pulmonary rehabilitation
- Strengthen **health psychology** offer to reflect multimorbidity
- Explore, develop and scale up **Heart failure@Home**
- Strengthen the **Cardiac Prevention Pathway** through behaviour change communications which will encourage people to seek advice/promote the importance of risk factor management

By 2029
- All patients with with suspected heart failure and NT-proBNP >400 ng/l will receive urgent referral for specialist assessment and echocardiography at Place
- All patients with advanced heart failures will receive Heart Failure Specialist advice or review
- Improved psychological wellbeing of patients with heart failure will increase healthy longevity, improving quality of life, preserving good mental health and cognitive function, and achieving health care savings on individual &system level.
- More people managed from the comfort of their home and improving virtual care
- Increasing number of patients will be able to self-manage their conditions

How this transformation programme reduces inequalities between BHR Places residents and communities:
- Through service standardisation- single point of access, standardised clinical management pathways across BHR Places, discharge process and information to primary care, access to advanced medications across BHR, referral criteria, use of patient literature and patient information sheet.
- HFrEF scheme will impact on these improvement areas: reduce waiting times, possible development of PHP, expansion of MDT to include renal and palliative care, additional training on EOL, UCP and relationship building with specialist palliative teams and promote education and self-care, and exercise programme
- The schemes will improve greater access to community interventions, digital solutions and health literacy support tailored to at-risk groups
- CR is part of a multilevel approach addressing barriers related to healthcare system access and improving provision, referral and participation in high risk groups

Key programme features and milestones:
- Establish Governance for 2023-24 and forward, including linkage to Place. Reporting at "End -to-End Pathways Working Group (COCWP) ongoing
- HFrEF Phase 2:
  - Review Phase 1 (Q1 23/24)
  - Ensure maximum utilisation of existing HFrEF service (from Q2 to Q4 2023/24);
  - Ensure that the service is using efficient and effective systems and technology to deliver the service
  - Ensure standard access to other services including; Dietetics/ NHS Psychological Therapies Service (IAPT)/ Health Psychology/ End of life-Co-ordinate My Care (CMC)/ Hospice/ Expert Patient Programmes (EPP) (Q1 23/24)
- HFrEF Phase 3:
  - Enhance and expand in business case HFrEF service
  - Create an innovative service that can respond and adapt to the changing needs of the local health economy (digital technology, NHS@Home)
- Business case for HFpEP in Q4 23/24
- Standardise community cardiac service with integration with acute-WX, BHRUT

Further transformation to be planned in this area:
- Over the next two to five years
  - Business case to stand up cardiac rehabilitation service for heart failure patients across BHR Places in community
  - Scoping opportunities for streamlining access to cardiac diagnostics/ ancillary for care

Leadership and governance arrangements:
- Level 1: Place based Partnership
- Level 2: LTC Board (or architype/successor)
- Level 3: NEL Cardiac Clinical Network

Success will depend on Collaboratives with BHRUT/NELFT; Place is a crucial determinant and NEL Business case process.
Given the increasing multimorbidity of LTCs, a cardiometabolic approach to risk and commitment to end-to-end pathways is important. Not viewing cardiac pathways in silos but understanding close links with Diabetes, Respiratory and CKD. Prevention including LA schemes directed at upstream.

Programme funding:
Current cost of HFrEF
- £750K

Estimated cost of HFpEF
- Yet to be determined (Source= unknown)

Key delivery risks currently being mitigated:
- Workforce to staff schemes: attraction and retention which will be mitigated through skill mix, new lower band roles and continued training for practitioners (Primary/Community)
- No identified funding to progress HFpEF thereby inequalities and inequities will be sustained

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Diabetes / Tower Hamlets, Newham & Waltham Forest place partnerships / Kay Saini kay.saini@nhs.net

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

By 2024
- The number of TNW residents with diabetes (T2) receiving eight care processes (8CP) in primary care increase in number (75%+); the quality of process checks improves allowing both better health and early referral when necessary (e.g. foot health or renal)
- CYP diagnosed with diabetes (T1) are supported by a Transition service (ages 12-25) that equips them for later-life and is supported by new capabilities of Insulin Pumps and Continuous Glucose Monitoring (CGM) and/or other NHSE/NICE recommendations for transitioning to adult care.
- Diabetic Foot Service continued for 12 consisting of 2WTE in partnership with Barts and NELFT
- Increased referrals to LCD, NDPP, Digital Weight Management by at least 15% in 23/24
- Review of pathway and referral timeline in all three places, aiming to achieve a seamless patient care and referral system between primary care, secondary care and community services
- Introduction of Healthcare Assistants across TNW to help achieve better outcomes (8 CPs, Social Prescribing, referrals, SE)

By 2026
- The level of 8CP delivery is high (85%+) and stable; year-on-year improvements in numbers controlled (target 75%+); QI improvements have led to improved referrals and starting to reduce care required for complications (e.g. amputations)
- CYP capacity at acute improved by Transition services whose first 'graduates' are expert-users in Pump and CGM technology which reduces hospital care and increases self-management
- Place-based diabetes pathways are functioning well in all three places; patients are better equipped with knowledge about their conditions and understand their condition better, including self-referrals, which leads to better quality of life
- New capabilities of Insulin Pumps and CGM are present in acute and community, which raises the current standard of diabetes care in TNW for T1, raising places' profile with neighbouring ICBs and nationally.
- Diabetic foot service consisting of 2.5WTE is embedded as a standard service, ensuring early intervention that leads to reduction of foot amputations
- Structured Education is embedded in all discussions between health professionals and patients, increasing referrals from 57% to 75%+

How this transformation programme reduces inequalities between north east London's residents and communities:
- Primary care delivery of diabetes care was significantly impacted by Covid-19; the evidence shows that in London that residents with diabetes but who did not get Covid-19 have experienced an increased death-rate. In addition, deprivation, ethnicity and the greater incidence of key workers in East London increases the risk to residents with diabetes.
- Foot amputations remain a concern across TNW, an area where significant work needs to be put in place to bring the rate of amputations to below national rates, showcasing TNW as a benchmark of good health outcomes
- Place-based community mobilisation, close collaboration with Public health around living with or avoiding diabetes will be critical in developing long term strategies, which should include a strong prevention agenda in all its operations, therefore collaboration with other sectors will be crucial; e.g. LA education dept to include aspects of diabetes prevention in their healthy living programmes.
- Hard to reach parts of the community due to cultural and/or language barriers will continue to be a priority for health care services in TNW calling for closer coproduction with local community organisations.

Key programme features and milestones:
- Establish Governance for 2023-24 and forward, including linkage to Place
- Primary care (Q1-Q4)
  - Delivery of LTC LIS and transition to LTC Outcomes Framework
  - Conclude pathway reviews in each place, producing an easy to follow procedure and diagram for healthcare professionals, made available as a point of reference to patients, family members and community organisations.
  - Reach a definitive decision re introduction of HCAs, including a detailed timeline for mobilisation (Q1)
  - Set up a steering group to review gaps in transitioning from T1 to T2 (Q2); including discussions provision of pumps; using BHR's findings as a benchmark for potential implementation a similar approach in TNW.
  - Review DISN services in each place in collaboration with clinical leads and other interested parties to establish if it is fit for service in each place and produce recommendations for improvement (Q3)
  - Finalise the Group Consultation Training across chosen PCN's (Q1); consider a wider offer in 24/25
- Secondary
- Business cases: Diabetic Foot Service
- Community
  - Link BP@Home with CVD so that the same process covers both diabetes and CVD (Q2)
  - Set dates for template training to be delivered by CEG to practices in each place (online)

Further transformation to be planned in this area:

Over next two to five years
- Prevention Diabetic Foot Disease given a high priority, seeking to reduce amputations significantly in each place aiming to raise each place's profile above national levels.
- aim to have 95% of patients completing 8CPs by 2026
- Establishing MDTs in WF and TH

Programme funding*:

Currently costed scheme,
- HCA Service £230K

Schemes being estimated
- Pumps, CGM* £600k (based on BHR)
- Admin support for MDT meetings in Newham: (TBC)

* Sources of funding to be identified

Leadership and governance arrangements:
- Level 1 – TWN LTC (or its successor)
- Level 2 – NEL Diabetes Clinical Network
- Diabetes Pathway Review Steering Group

Success will need co-ordination or contract management with:
- Networks; NHSE London, Primary Care (local and London), CVD, Obesity, Renal, Hypertension, UCLP
- Partners; Barts, RLH, ELFT, NELFT, PCNs, Prescribing, Community Pharmacy
- Other providers; Xyla, CEG, Oviva, Federations, Diabetes UK, etc..

Key delivery risks currently being mitigated:
- Funding: reduced funding will be the main factor in delivering new programmes such as HCAs and/or embedding Diabetic Foot service post 23/24.
- Workforce both in the team and in front line service could be an factor in delaying delivery of programmes inter-provider work and skills transfer (e.g. pumps) plus training (CEPN)
- Prolonged process of restructure at NEL is likely to cause uncertainty and delays at local level.
- Lack of clarity from ICB about roles, guidance, expectations, and timescales including mixed messages that will cause unnecessary delays and confusion.

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Cardiology / Tower Hamlets, Newham, and Waltham Forest place partnerships / William Cunningham-Davis

The benefits that Tower Hamlets, Newham, and Waltham Forest residents will experience by April 2024 and 2029:

By 2024
- Reducing variation in service provision for people with **heart failure**
- Reducing variation in service provision for residents requiring **cardiac rehabilitation (CR)**
- **Improving CR** pathways, as well as uptake and completion rates amongst eligible population
- Improved early and accurate diagnosis of CVD through **BP screening, lipid testing, and AF detection**
- Improved access to hypertension and anti-coag. monitoring services, including **optimisation of meds**

By 2029
- Increasing number of patients engaging with self-management tools and initiatives
- Improve Community Cardiology service provision and access to care closer to home

How this transformation programme reduces inequalities between TNW Places residents and communities:
- The ongoing and new schemes will improve access to community interventions, as well as self-management
- By proactive case finding in areas of deprivation and amongst communities less likely to access healthcare to reduce the prevalence gap
- By Improving access to services by delivering care closer to home, including self-management
- By taking a population management approach to tackle health inequalities
- By reducing variation in care and targeted communication and support material to overcome language barrier/cultural difference
- Expansion of the CR service has included an evaluation exercise of other CR services within the NEL system, the outcome of which is being used to inform the roll-out and delivery of the service. This service will improve accessibility for local residents in and around Waltham Forest, feeding into existing pathways, including community HF, and facilitating direct referral pathways from primary care, as well as self-referral.

Key programme features and milestones:
- Complete hypertension inequalities pilot to reduce number of uncontrolled hypertensive patients against baseline – Q3
- Ongoing delivery of communications plan to improve uptake and utilisation of home BP monitors – Q1 & Q2
- Develop business case for proactive case finding of patients at risk of developing AF and hypertension – Q4
- Launch CR service in Whipps Cross – Q2
- Review and align anti-coagulation services in Newham with LTC outcomes framework and identify opportunities to meet IIF targets
- Launch InHIP – diagnostic and case-finding of hypertension & hyperlipidaemia and medicines optimisation - Q2
- Review Community pharmacy anti-coagulation service – Q2
- Scoping exercise for community based anti-coagulation service to include DOAC initiation pending review of anti-coagulation provision at NEL level (TBC)
- Develop BC for Community cardiology service in Newham – Q3/Q4
- Evaluate Community anti-coagulation service in WF – Q4

Further transformation to be planned in this area:

Over the next two to five years
- Scoping opportunities for cardiac diagnostics at Community diagnostic centres

Programme funding:
- Hypertension inequalities pilot £30K
- InHIP (Newham) £50k
- Whipps Cross CR £365k
- BP@Home extension - £15K
- Other funding TBC

Leadership and governance arrangements:
- Cardiac Clinical Reference Group (NEL)
- North London Cardiac Rehabilitation working Group
- Place-based Partnership Groups
- Primary Care Transformation Groups

Key delivery risks currently being mitigated:
- Prolonged process of restructure at NEL and impending change in team capacity, portfolio, and function may impact on delivery of workstreams – plans developed for ongoing delivery
- Ongoing recruitment and retention challenges across the system, i. e. cardiac rehabilitation specialists – opportunities being considered to recruit exercise specialists with transferable skills and knowledge

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

Respiratory: Transformation in NEL

North East London Health & Care Partnership

Respiratory / TNW / [William Cunningham-Davis, william.cunningham-davis@nhs.net]

The benefits that Tower Hamlets, Newham and Waltham Forest residents will experience by April 2024 and April 2026:

- Improved early and accurate diagnosis of asthma and COPD by implementation of Respiratory Hublets
- Improved outcomes for patients with respiratory disease via the provision of information to support better self-management
- Greater access to Pulmonary Rehabilitation service to support better outcomes from respiratory disease
- Reduction in number of people smoking to below England average by 2026.
- Less exacerbations and hospital admissions through better management in the community
- Improved outcomes from medicines through specialist led reviews in Primary Care
- Improved seamless Respiratory Pathway for better management of respiratory conditions

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

- By proactive case finding in areas of deprivation and amongst communities less likely to access healthcare to help address the prevalence gap
- By applying a population management approach to identify health inequalities and implementing bespoke strategies
- By reducing variation in care through better access to services, delivering care closer to home and self-management tools/information which takes in to account language barriers/cultural differences
- By increasing uptake of flu, covid-19 and pneumococcal vaccinations to support patients to reduce infective exacerbations and emergency hospital admissions due to those exacerbations, through local targeted campaigns
- By targeting those patients at high risk of admissions to prevent worsening of their condition through earlier interventions

Key programme features and milestones:

Prevention and Earlier and Accurate Diagnosis

- Delivery of communications plan to increase referrals in to pulmonary rehabilitation services - TNW
- Engagement via PCNs to identify and refer patients with undiagnosed /high-risk COPD in Primary Care using CEG searches - TNW
- Champion The Healthier Lives programmes in Newham
- Re-Procurement of TH Good Moves Service
- Mobilisation of the respiratory Hublets at Place- TNW

Better Management

- Complete Respiratory inequalities pilot to reduce number of uncontrolled respiratory patients against baseline – WF
- Review the current NELFT Respiratory specification and pathway to identify gaps and inequality in respiratory provision across WF. Development of a concept paper and subsequent development of BC for NELFT community service
- Upskill workforce via training and education sessions to support the delivery of better management in Primary Care-TNW
- Socialise the Pulmonary Rehabilitation Service in Primary Care through local patient campaigns- TNW
- Support the development of the business case for a Home Oxygen Service -Newham
- Embed UCLP risk stratification search via PCN engagement to help identify and priortise patients in need of further support with their management -TNW
- Review of the LTC data sets to devise realistic placed based targets for LTC LIS. Collaborate with Primary Care and support roll out of the LTC LIS and transition to LTC Outcomes Framework- TNW
- Review and update draft respiratory pathway- TNW
- Continue to input into the WF Delivery Groups to support mobilisation of Care closer to home & Centre of excellence programme with the aim to better manage patients who at the highest risk of a non-elective admissions tbc
- Re-introduce the specialist respiratory reviews service, prioritising PCNs with patients at highest risk of an exacerbation-WF

Further transformation to be planned in this area:

Over the next two years

- Review of the NELFT respiratory Service
- Patient Education and support tools
- Develop appropriate options and healthy-living programmes that resident want to complete
- Integration with related schemes as they develop e.g. Obesity, Hypertension, Renal
- Re-Procurement of TH Good Moves Service
- Explore the opportunities to incorporate digital and remote monitoring services to support patients with LTC
- Embed the use of the risk stratification approach in BAU to support prioritisation of high risk patientsatory pathway

Programme funding:

- Primary Care funding, SDF funding
- Part of WX redevelopment funding Section 256 funding

Leadership and governance arrangements:

- NEL Respiratory Clinical Network
- WF LTC Delivery Group
- Primary Care transformation Delivery Board

Key delivery risks currently being mitigated:

- Funding not secured due to a financial reduction in NHS
- Insufficient LTC staff in TNW due to lack of permanent staff and team vacancies
- Sustainable delivery due internal re-structure in ICB
- Non-engagement from PCNs
- Workforce: attraction and retention could limit development;

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Improving outcomes for people with long term health and care needs /City and Hackney Place / Nina Griffith, Workstream Director, NHS NEL, nina.griffith@nhs.net

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

- April 2024:
  - Health outcomes for residents with LTCs have improved to at or near pre-pandemic levels
  - Residents have the opportunity to participate in self-management programmes (e.g. BP@home or Digital Structured Education for diabetes)
  - Residents have access to high quality diagnostics locally – e.g. Spirometry
- April 2026:
  - Communities that find it harder to access services will have opportunities to engage
  - Increased focus on prevention and "upstream services" such as community and primary care
  - Access to out of hospital care at time of need e.g. rapid diuresis service for Heart Failure services

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

- By working with our voluntary sector providers to engage specific communities e.g. through our community champions programme and Social Prescribing Outreach Programme
- By working with our population health hub and PCNs to identify and address specific inequalities
- By working with the neighbourhoods team to pilot approaches to including wider determinants of health in our approach to condition management
- By making our services more accessible to residents such as via women's health hubs in the community
- By ensuring that risk stratification approaches are embedded in our local approach to population health management

Key programme features and milestones:

- Local LIS for Long Term Conditions
- NEL LTC outcomes framework
- Development of a system-wide personalised care strategy
- Ongoing work with local Public Health to join up prevention approaches on lifestyle services such as weight management and smoking cessation
- Building on existing good relationships between primary and secondary care clinicians to achieve excellent care for residents: including end to end clinical pathways, outpatient transformation and local approaches to implementing National or Regional projects
- Link with NEL wide clinical networks to align local and regional priorities

Further transformation to be planned in this area:

Over the next two years

- Continued focus on primary / secondary care interface to strengthen partnerships and best outcomes for residents
- Scope out further opportunities to bring specialist expertise into community settings
- Link to other programmes of work such as digital and out of hospital care to maximise benefits

Over years three to five

- Embed personalisation via the neighbourhoods transformation work
- Refine approach to risk stratification in primary care to enable targeted approach

Programme funding:

- Local LIS funding
- NHSE funding for specific programmes such as diabetes
- Non-recurrent funding for pilot schemes

Leadership and governance arrangements:

- Local clinical leads in partnership with LTC, planned care, neighbourhoods and PH teams
- Place based partnership Delivery Group
- Neighbourhood Health and Care Board and City and Hackney Health and Care Board

Key delivery risks currently being mitigated:

- Reduced funding for innovation and pilots (including from NHSE)
- Recruitment difficulties for some front line staff groups
- Lack of primary and secondary care clinical capacity to drive forward change

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

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

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

- April 2024:
  - Consistent access to urgent community response as a safe alternative to ED for patients in crisis
  - Access to a frailty and respiratory virtual ward as a safe alternative to hospital admission
  - Better continuity of care post crisis to ensure complete recovery and reduce risk of further crisis
- April 2026:
  - More people managed safely in the community as an alternative to ED / acute admission
    - Increased - supported by appropriate use of technology
    - Increased range of clinical conditions to meet assessed need
  - Fewer people experiencing crisis
  - Increased patient choice and personalised care at home

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

- By supporting vulnerable frail cohort to receive consistent acute level care in their own homes
- By ensuring equity of access and supporting referrals from system partners
- By reducing variation in avoidable use of urgent and emergency care services including LAS and ED
- By providing flexible employment opportunities
- By using population health data to target investment in areas of greatest assessed need

Key programme features and milestones:

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

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

Further transformation to be planned in this area:

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

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

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

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

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

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Cardiovascular Disease Prevention / Redbridge Place based Partnership / Tracy Rubery, Borough Director (tracy.rubery@nhs.net)

The benefits that Redbridge residents will experience by April 2024 and 2029:

By 2024

- Utilise PHM to articulate risk factors and classification for CVD at Place
- Identify demographic risk modifiers for every individual registered in primary care
- Improve early detection of CVD especially of people with *high risk conditions*
- Population-level approaches to cardiovascular disease: *physical activity; smoking and tobacco use, alcohol, environment, air pollution and climate change*
- Risk management of disease-specific cardiovascular disease: *hypertension, coronary artery disease, heart failure, chronic kidney disease, atrial fibrillation, multimorbidity*

By 2029

- Leverage analytics/algorithms and visualisation tools to understand, track and report on population activity and measure improvements
- Greater peer led community support and engagement to enable self-care and lower acute care utilisation
- >85% of expected number of people with AF are identified; >90% of patients with AF who are already known to be high risk of stroke adequately anticoagulated
- >80% of the expected number of people with high blood pressure are diagnosed; >80% of the total number of people already diagnosed with high blood pressure are treated to target as per NICE guidelines
- >75% of people aged 40 to 74 have received a formal validated CVD risk assessment and cholesterol reading recorded on primary care data system in the last five years; >45% of people aged 40-74 identified as having a 20% or greater 10-year risk of developing CVD in primary care treated with statins; >25% of people with familial hypercholesterolaemia (FH)

How this transformation programme reduces inequalities between Redbridge's residents and communities:

- Getting upstream of cardiovascular disease, maximising condition identification, referrals and first outpatient attendance. This will include a differential focus on hypertension, diabetes, coronary heart disease, chronic kidney disease and atrial fibrillation.
- Removing the practical barriers that hold back some residents from seeking and ensuring their uptake of individual or population interventions
- Seeking to appropriately compensate voluntary community sector providers by recognising the increased costs associated with working with more deprived communities and by removing the financial barriers to residents taking up care options (for example, loss of benefits whilst in care or recovering from ailment).
- Improving the quality of patient-health professional decision-making and addressing digital exclusion, so that access virtual care, digital reminders and using algorithms to prioritise waiting times

Key programme features and milestones:

- Governance at Place from 2022/23 and forward, including sustained reporting at "End -to-End Pathways Working Group (COCWP)

Further transformation to be planned in this area:

- Over the next two to five years
  - ➢ Development of CVD dashboards that provide actionable insights
  - ➢ Scoping opportunities for standardising access and delivering care from 'Cradle to Grave' including community health, public health.

Programme funding:

CVD Prevention interventions

- Unknown

Leadership and governance arrangements:

- Level 1: Place based Partnership

Working groups established – CVD Prevention .

- Level 3: NEL Cardiac Clinical Network; NEL Renal Clinical Network, NEL Respiratory Clinical Network

Key delivery risks currently being mitigated:

- No available funding dedicated to CVD Prevention interventions

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Perinatal Mental Health Improvement Network / MHLDA Provider Collaborative / Pauline Goffin, Director of Mental Health, Learning Disabilities and Autism, NHS NEL, pauline.goffin@nelft.nhs.uk

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

- April 2024:
  - Improved access to specialist perinatal and maternal mental health services (8.76% by March 2024)
  - X additional peer support workers established within perinatal services across NEL
- April 2026:
  - Improved access to specialist perinatal and maternal mental health services (10.1% by March 2026)
  - Whole-pathway review completed as part of Perinatal Provider Collaborative development

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

- More support for women, pregnant people and partners throughout the perinatal period in every borough in north east London
- Increased availability of peer support workers, promoting access for underserved communities, and expanding our workforce so that is more representative of the communities we serve
- Through our improvement network approach, we are harnessing clinical and service user leadership, and using quality improvement and population health management tools to understand and address inequities in outcomes and experience for people with intersecting protected characteristics

Key programme features and milestones:

- Perinatal Improvement Network established – led by clinicians and service users – to promote and spread best practice, and drive service design and transformation
- *If approved* completion of due diligence and mobilisation work to transfer perinatal specialised commissioning responsibilities for the population to a NCEL Perinatal Provider Collaborative (hosted by ELFT) by October 2023
- Service user-led review of peer support workers within perinatal mental health services completed by Dec 2023 (interdependency with Lived Experience Leadership Programme)
- Review and refresh of maternal mental health services (specialist psychological interventions) by March 2024

Further transformation to be planned in this area:

Over the next two years

- Delivery of the requirements of the NHS Long Term Plan as regards perinatal mental health

Over years three to five

- If NCEL Perinatal Provider Collaborative is financially viable, there will be further longer-term opportunities for improving the join up and interrelation of services across the entire perinatal mental health pathway

Programme funding:

- 2023/24 funding for perinatal mental health TBD (from MHIS / SDF)
- Potential funding associated with transfer of perinatal specialised commissioning budget: £4.8m

Leadership and governance arrangements:

- Perinatal Mental Health Improvement Network to lead
- Reporting into MHLDA Collaborative Committee
- NCEL Perinatal Collaborative governance arrangements TBC

Key delivery risks currently being mitigated:

- The transfer of the specialised commissioning perinatal mental health responsibilities to a local provider collaborative may be financially risky as the envelope is small. This is being mitigated through a thorough due diligence process.
- NHS long term plan delivery risks (i.e. non-compliance with national targets) are being mitigated through the development of the Improvement Network and greater collaboration between services across NEL

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

IAPT Improvement Network / MHLDA Provider Collaborative / Dan Burningham, Programme Director - Mental Health, NHS NEL dan.burningham@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2025:

- April 2024:
  - 28.9% of people with common mental health conditions accessing talking therapies by end-March 2024
  - Increased availability of NICE-recommended group based interventions across NEL
- April 2025:
  - 30% of people with common mental health conditions accessing talking therapies by end-March 2025 (pending funding settlement)
  - Increase in access to talking therapies for people with long term conditions

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

- The IAPT Improvement Network is focused specifically on increasing access to talking therapies for people in every borough across NEL, harnessing clinical and service user leadership to spread best practice and improve outcomes and experience, and to improve value
- Our IAPT Improvement Network will also have a specific lens on health inequalities, and will be hosting a Population Health Fellow to help us to systematically understand which groups (e.g. people with LTCs, older adults, black men) are underserved by talking therapy services, and using QI tools and techniques to improve access, experience and outcomes for those groups

Key programme features and milestones:

- IAPT Improvement Network is operational and leading the programme of work in partnership with place leads. The Network is led by clinicians and experts by experience
- New workstream focusing on increasing productivity across all IAPT services will be established, with clear plan in place for enhancing service productivity across NEL by September 2023
- New workstream focusing on addressing inequities in access and experience, led by a Population Health Fellow, will be established with clear work plan in place by December 2023
- Work to understand additional growth required to achieve 30% access target (taking account of any productivity gains) completed by March 2024

Further transformation to be planned in this area:

- Over the next two years
  - To be populated following IAPT Network Away Day on 3rd March 2023
- Over years three to five
  - To be populated following IAPT Network Away Day on 3rd March 2023

Programme funding:

- In 2023/24 this programme will be delivered at cost to providers – all funding is going towards expanding and improving IAPT services rather than programme delivery

Leadership and governance arrangements:

- IAPT Improvement Network to lead
- Reporting into MHLDA Collaborative Committee and to place-based partnerships re: local performance

Key delivery risks currently being mitigated:

- NHS long term plan delivery risks are being mitigated through the development of the Improvement Network and greater collaboration between services across NEL
- In some boroughs reduced access has been caused by high numbers of staff vacancies. Through focused efforts to increase recruitment and retention, and work across the Improvement Network to harness mutual support, these are largely mitigated for 2023/24

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Improving health outcomes and choice for people with severe mental illness / MHLDA Provider Collaborative / Dan Burningham, Programme Director - Mental Health, NHS NEL dan.burningham@nhs.net

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

- April 2024:
  - 60% of people receive an annual physical health check across NEL
  - 1000 active users of Patient Knows Best across NEL (patient-held record)
  - 300 additional personal health budgets for people with SMI
- April 2026:
  - 70% of people receive an annual physical health check across NEL
  - 2000 active users of Patient Knows Best across NEL (patient-held record)
  - SMI physical health outreach offer available in every borough for high-risk patients

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

- By focusing on the physical health needs of people with severe mental illness, we will be working to directly reduce the mortality gap between this group and the wider NEL population (which began to increase during the pandemic)
- The emphasis on targeting high-risk service users (people with SMI who are infrequent users of primary care and/or have never received a health check) through new culturally sensitive community outreach services will address health inequities driven through structural inequalities, particularly for minoritised communities across NEL

Key programme features and milestones:

- Supporting the work led by place-based mental health partnerships and teams to increase the uptake of SMI physical health checks; sharing best practice and learning from new and novel approaches
- Supporting the design and implementation of outreach approaches targeting high-risk service users, requiring culturally competent and sensitive approaches to tackling stigma and structural inequalities
- Supporting places to implement the patient-held record, known as Patient Knows Best (PKB), giving service users greater agency and control over their care plan
- Supporting places to increase the number of personal health budgets for people with serious mental illness, sharing best practice and learning from elsewhere

Further transformation to be planned in this area:

- Over the next two years
  - Increased role for Lived Experience Leaders in driving the Personalisation agenda
  - Closer collaboration with the VCSE on community outreach
- Over years three to five
  - NEL-wide digital mental health offer to support and underpin the use of PKB and personal health budgets

Programme funding:

- £1,735,000 non-recurrent funding from SDF and MH slippage (personal health budgets)
- £210,000 TBC (Patient Knows Best)

Leadership and governance arrangements:

- Led within places, supported by the MHLDA Collaborative programme
- Reporting into MHLDA Collaborative Committee and to place-based partnerships re: local performance

Key delivery risks currently being mitigated:

- There are issues with the integration engine to enable bi-directional data flows between trust records and Patient Knows Best. However, work is currently underway with digital leads to resolve this.
- There is currently a lack of lived experience leadership in these workstreams. The resources allocated to establishing the NEL Lived Experience Leadership Programme will mitigate this throughout 2023/24

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Improving outcomes and experience for people with dementia and their carers / MHLDA Provider Collaborative / Dan Burningham, Programme Director - Mental Health, NHS NEL dan.burningham@nhs.net

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

- April 2024:
  - All places across NEL are compliant with the 66.7% dementia diagnosis rate
  - Dementia pathways in every place are comprehensively mapped with opportunities for improvement identified, including greater collaboration with the VCSE
- April 2026:
  - Improved access to evidence-based treatment and support in every borough
  - Reduction in preventable admissions to hospital for people with dementia
  - Increase in number of dementia carer assessments in every place across NEL

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

- Opportunity to share learning between places and explore opportunities to expand on good practice, including the award-winning models of care in Hackney that provide people with a continuous and consistent source of support from dementia diagnosis, all the way though to end of life
- To ensure that evidence-based support and treatment is available in all places, including (but not limited to); cognitive stimulation therapy, psychological therapy and signing for the brain
- By systematically understanding unwarranted variation in diagnosis rates for different communities, and developing culturally competent approaches to reducing inequity and tackling stigma

Key programme features and milestones:

- Establish a Dementia Improvement Network, led by lived experience leaders and clinical and care professionals, including social care
- Use the clinical expertise across the Network to understand immediate opportunities for improving the dementia diagnosis rate, including any digital solutions, by June 2023
- Lived Experience Leaders to identify key opportunities for improving support to carers by September 2023
- Deliver improvements in dementia diagnosis rate in every borough by March 2024
- Undertake comprehensive dementia pathway mapping in each place to understand existing service provision and any gaps / inequities between places by April 2024

Further transformation to be planned in this area:

- Over the next two years
  - Increase the number of peer support roles involved in dementia support services, including for carers
- Over years three to five
  - Explore opportunities to build on our existing relationships with academic institutions to lead our own research projects on dementia prevention

Programme funding:

- There is no resource currently allocated to delivering this programme

Leadership and governance arrangements:

- We would establish a new Dementia Improvement Network to lead in conjunction with place-based teams
- Reporting into MHLDA Collaborative Committee and to place-based partnerships

Key delivery risks currently being mitigated:

- Dementia sits in multiple portfolios (e.g. primary care, frailty, mental health, end of life, planned care, social care) which means that there is a lack of clarity across places and the system on leadership and improvement goals. This risk could be mitigated through the resourcing and establishment of a NEL wide-programme, led by the MHLDA Collaborative, with strong links into place-based partnerships and other provider collaboratives and ICS workstreams

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Crisis Improvement Network / MHLDA Provider Collaborative / Jamie Stafford, jamie.stafford@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2025:

- April 2024:
  - Reduction in proportion of 12 hour waits in emergency departments for all ages
  - Crisis alternatives operational in Waltham Forest and Barking & Dagenham
  - Reduction in system-wide bed occupancy to below 92%
- April 2025:
  - NHS 111 press 2 for mental health available across all places in North East London
  - Demonstrable progress with engaging the VCS in developing our crisis prevention approach
  - Reduction in S136 activity by 10%

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

- We will reduce unwarranted variation in 12 hour waits for people with mental health needs who attend emergency departments (with a focus on King George's and Queens Hospitals)
- Working to address the over-representation of black men being detained for mental health treatment through better join-up with the voluntary & community sector, and focusing on prevention
- Rolling out NHS 111 press 2 for mental health so that everyone can have easier access to mental health support
- Ensuring that crisis alternatives are available in every borough across NEL (including crisis houses and crisis cafes)

Key programme features and milestones:

- Crisis Improvement Network set up by April 2023 (with service user-led Think Tank established) to drive strategic redesign and develop creative approaches to prevention
- Review of Psychiatric Liaison Services across NEL completed, with recommendations for service improvements completed by September 2023 (including opportunities to make them all-age)
- Additional bed capacity brought online and operational by October 2023 (in preparation for winter)
- First roll-out of NHS 111 press 2 for mental health by end of March 2024 (may be staggered by geography)
- Work undertaken with Lived Experience Leaders and VCSEs to explore crisis prevention in the context of key health inequalities, with investment plans by April 2024

Further transformation to be planned in this area:

- Over the next two years
  - Increase no. peer support workers in crisis services
  - Closure of s.136 suite at Newham Centre for MH
  - Review and potential expansion of MH joint response cars
- Over years three to five
  - Review and redesign of crisis alternatives across NEL
  - Lived Experience-Led crisis service developed

Programme funding:

- TBC – pending finalisation of financial planning

Leadership and governance arrangements:

- Crisis Improvement Network to lead programme of work
- Reporting into MHLDA Collaborative Committee and NEL UEC Boards as required

Key delivery risks currently being mitigated:

- Data has been inconsistent and unverified, making it difficult to quantify and understand the problems we need to solve. Work underway with ICB data team and trust BI leads to develop common view of performance
- System-wide bed occupancy continues to be high, due to increased lengths of stay. Work underway to increase acute bed capacity to ease inpatient pressures and reduce waiting times. Also linking with places to maximise discharge pathways and step-down

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Children and Young People's Mental Health Improvement Network / MHLDA Provider Collaborative / Carys Esseen, carys.esseen@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2025:

- April 2024:
  - 24,322 children and young people accessing mental health support across NEL
  - Roll-out of Intensive Community CAMHS Services (ICCS) across INEL
  - 95% of referrals to eating disorder services seen within 1 week (urgent) or 4 weeks (routine)
- April 2025:
  - 25,000 children and young people accessing mental health support across NEL
  - Talking therapies for anxiety and depression expanded to include 16 and 17 year olds
  - Model for mental health crisis alternatives for children and young people developed

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

- Increasing access to support for children and young people (CYP) in every borough across NEL, with additional resources diverted to support those boroughs with the greatest unmet needs
- Broadening offer of support across NEL with a greater emphasis on wellbeing, prevention, targeted support, support to parents / carers, and culturally competent care
- This programme links closely with the LDA Improvement Programme, the Crisis Improvement Network and the Babies, Children and Young People's programme to ensure that the intersecting needs of children and young people are considered, and that the specific needs of children and young people are considered in different service settings e.g. A&E

Key programme features and milestones:

- CYP Mental Health Improvement Network is operational and leading the programme of work in partnership with places and other programmes e.g. BCYP. The Network is led by clinicians and experts by experience
- Coproduction event planned for April 2023 to support the development of Lived Experience Leaders in CYP
- CYP Mental Health and Emotional Wellbeing Delivery Plan published in 2023/24 (timelines TBC), covering inequalities, workforce and iThrive implementation
- Expansion of ICCS across City and Hackney and Tower Hamlets so that there is full NEL coverage by March 2024
- Crisis alternatives codesigned with service users and carers and plans developed by March 2025
- Expansion of talking therapies to 16/17s by March 2025

Further transformation to be planned in this area:

- Over the next two years
  - Social prescribing plan for CYPs developed in line with iThrive principles with service users
- Over years three to five
  - Comprehensive digital offer underpinning NEL mental health and emotional wellbeing approach
  - 100% coverage of mental health and emotional wellbeing support in schools via MHSTs or equivalent

Programme funding:

- £4,345,000 for 2023/24 from CAMHS SDF
- Programme leadership resource TBC (this is non-recurrently funded by NEL ICB)

Leadership and governance arrangements:

- Led by the CYP Mental Health Improvement Network and place-based teams
- Reporting into MHLDA Collaborative Committee, BCYP Programme and place-based partnerships

Key delivery risks currently being mitigated:

- NHS long term plan delivery risks are being mitigated through the development of the Improvement Network, greater collaboration between services across NEL and Service Development Funding (however, there may still be a gap)
- There is currently a full-time programme manager supporting this work, funded by the ICB non-recurrently. There is no clarity on longer term resource available.

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Mental Health/ City and Hackney/ Dan Burningham, Programme Director - Mental Health, NHS NEL dan.burningham@nhs.net

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

- April 2024:
  - 2000 co-produced digital personalised mental health care plans
  - 25% reduction in high risk people with SMI without a physical health check
- April 2026:
  - 3,000 co-produced digital personalised mental health care plans
  - 75% reduction in high risk people with SMI without a physical health check.

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

- People with SMI have a health inequality gap of 10-15 years reduced life expectancy.
- By 2026 3,000 more people with SMI will have access to their own health data and personalised co-produced health improvement goals
- By 2026 the number of people with SMI who have not had a physical health check will have been halved through our SMI outreach programme aimed at reaching under served and marginalised groups.

Key programme features and milestones:

- Physical health checks identify health risks early allowing lifestyle changes and medical interventions to be made to prevent deterioration.
- Co-produced care plans support personalised health improvement linked to physical health checks.
- Milestone 1: establishment of SMI outreach teams in all 8 PCNs by April 2025. Recruitment: 4 WTE HCAs
- Milestone 2: PKB digital platform accessed by all SMI HCAs and mental health community teams by April 2025.

Further transformation to be planned in this area:

- Over the next two years
  - Personalised care plans will be supported by health coaching and access to peer support
  - More psycho-educational materials will support patients
- Over years three to five
  - Personalised care planning will become more interactive through bi-directional feedback

Programme funding:

- SMI outreach: £240K workforce (MHIS)
- Digital care plans (PKB contract NEL wide funding)

Leadership and governance arrangements:

- SMI physical health improvement network
- PHR NEL Programme Board
- City and Hackney Mental Health Integration Committee

Key delivery risks currently being mitigated:

- Failure to recruit – plan early
- Teams do not adopt because of other priorities – ensure organisational leaders are on board and the operational level are engaged, informed, inspired and trained

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Adult Mental Health / Newham Place-Based Partnership / Richard Fradgley, Executive Director of Integration, ELFT rfradgley@nhs.net

The benefits that Newham's residents will experience by April [2024] and April [2026]:

- April 2024:
  - Culturally appropriate approaches and services in place
  - Increased opportunities for peer support, lived experience and employment
  - Improved care provision and experience of services
- April 2026:
  - X
  - X
  - X

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

- By identifying and agreeing priorities that are locally focussed based on data and evidence
- By focussing on universal to specialist level of needs using population health management approaches
- By having a strengthened focus on equity, equality and challenging racism and all forms of discrimination
- By working with and across all system partners, with a strengthened focus on residents voice from the start of any project

Key programme features and milestones:

- April 2023 – Agree a small number of initial priorities for partners to work together to deliver better outcomes for residents, staff and the system
- Develop and integrate our services including Supported Living, Rehab & Complex Care pathways
  - Forensic Step Down
  - High Needs / Residential Care
  - Supported Living Quality Standards
    - Develop and deliver a Recovery College service

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

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

Leadership and governance arrangements:

- Newham Adult Mental Health Partnership Board chaired by the Clinical Lead and a resident, which reports up to the Newham Health and Care Partnership Board and NEL MHLDA Committee

Key delivery risks currently being mitigated:

- X
- X

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Mental Health – living well programme / Havering / Luke Burton, Borough Director, luke.burton1@nhs.net

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

Mental Health - by April 2024:
- Will be able to access three new local mental health and wellness teams
- For residents with acute mental health needs who require inpatient care they will be admitted to more local units rather than being placed out of borough
- For those residents with severe mental illness, they will be supported to find and retain employment through the launch of the Individual Placement Support service
- Improved access to perinatal mental health services with increased access for local woman and their families
- Patient will have faster access to dementia diagnosis services with improved pre and post diagnostic support
- Suicide prevention – Provided with enhanced prevention support for those at high risks of suicide and self-harm

Mental Health – by April 2026:
- Faster access to early intervention services for those experiencing psychosis due to increased investment in Early Intervention team workforce capacity
- Crisis Services – access to improved 24/7 crisis response services
- Access to crisis lines through a new Single Point of Access (SPA) and timely, universal mental health crisis care through the development of a bespoke 111 Service
- Crisis Alternatives - Increased and improved alternative forms of provision for those in crisis e.g. sanctuaries/safe havens; crisis houses; crisis cafes
- Physical Health – improved physical health checks and access to interventions, through increasing the volume and quality of Serious Mental Illness (SMI) Physical Health Checks
- Expanded access and availability of IAPT (Improved Access to Psychological Therapy) provision for those experiencing Long Term Conditions i.e. due to long covid
- Improving access and outcomes for BAME (Black, Asian and Minority Ethnic) residents using talking therapies through targeted support

How this transformation programme reduces inequalities between north east London's residents and communities:
- Improving health checks for those diagnosed with a serious mental illness is one of the health inequalities listed in the Core 20 Plus 5 national health inequalities programme, through improving our local offer we aim to exceed the national target of 60% of those living with an SMI receiving their annual health check
- Traditional services and pathways do not work well for those with mental health issues, for example a standardised stop smoking service model shows poor quit rates amongst those with mental health, by commissioning tailored stop smoking services for those with mental health this reduces the inequalities a standardised model creates, a number of improvements to dementia pathways, local mental health and wellness teams, perinatal services and crisis services are all being made to help create equity.

Key programme features and milestones:
- Commission a specialist provider to deliver SMI Physical Health Checks by Dec-23
- Ensure 70% of SMI patients receive an annual health check by Mar-24
- Ensure dementia diagnosis rate is at least 66.7% by Mar-24
- Launch new Havering Dementia Strategy by Dec-23
- Develop local psychological therapy pathways and services for complex patients with EUPD (Emotionally Unstable Personality Disorder) by Mar-23.

Further transformation to be planned in this area:

Over the next two years
- ➢Further improvements to suicide prevention services
- ➢Further improvement to perinatal mental health services

Programme funding:
- ➢Funding is under discussion as part of SDF and MHIS
- ➢Funding for SMI PHCs for 23/24 is around £129k awaiting confirmation from NEL SMI PHCs Delivery Group

Leadership and governance arrangements:
- Work overseen by Havering Mental Health Delivery and Oversight Group – accountable to Havering Place Based Partnership Board

Key delivery risks currently being mitigated:
- Finance is a significant risk to the mental health programme due to system pressure in urgent & emergency care
- Workforce significant risks as recruitment to the mental health roles are very hard to recruit to due to lack of available skilled workforce

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Mental Health / Warwick Tomsett, Borough Director, Warwick.Tomsett@towerhamlets.gov.uk

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

- A reduction in health Inequalities in terms of access, experience and outcomes
- More paid employment opportunities for people with mental health needs, including *people participation* as a route into paid employment
- A more preventative approach to mental health conditions
- Improving neurodevelopmental pathways, ensuring that people with ADHD and Autism have improved outcomes and experience
- Improved experience and outcomes for young people transitioning to adult services, including a more preventative approach to supporting them into adulthood

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

- Addressing and improving employment outcomes for those with mental health conditions and/or requiring mental health support
- Addressing and improving inequalities in access, experience and/or outcomes of mental health services where these exist
- Improving outcomes and experience for those with **ADHD** and **autism**
- Supporting young people with mental health conditions and/or requiring mental health **support transition into adulthood** with the required level of support

Key programme features and milestones:

- Creating paid employment opportunities for people with mental health needs, including people participation as a route into paid employment
- Improving the experience and outcomes for young people transitioning to adult services, including thinking about a more preventative approach to supporting them into adulthood
- Improving neurodevelopmental pathways, ensuring that people with ADHD and Autism have improved outcomes and experience
- Deep dive to understand the specific communities / characteristics of people impacted by:
  - premature mortality for people with SMI
  - poor health expectancy for women
  - cost of living crisis

Further transformation to be planned in this area:

- Over the next two years
  - Develop a plan to ensure key programmes are delivered
  - Identify further preventative approach and link more with TH public health team

Programme funding:

- Mental Health Investment Standard
- Core Based Funding from LBTH and ICB
- Better care Funds (BCF)

Leadership and governance arrangements:

- Principal strategic and operational oversight by Mental Health Partnership Board
- Monthly delivery oversight by Local Delivery Board
- Quarterly assurance monitoring at THT Executive Board

Key delivery risks currently being mitigated:

- Need to work up project and transformation plan as this is additional/new life course
- Gap in project governance and PMO support

Alignment to the integrated care strategy:

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

Transformation in NEL

North East London Health & Care Partnership

Mental Health / Waltham Forest / Sue Boon- sue.boon@nelft.nhs.uk

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

- April 2024:
  - Improved access to mental health interventions and support in localities through primary care
  - Their mental health needs will be considered holistically alongside their physical health, social care, housing and other needs
  - Improved experiences in health and social care of people living with Dementia
- April 2026:
  - We will reduce the health inequalities experienced by those who have MH support needs and/or who are homeless

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

- By linking with the evidence and action plan from the Marmot Review
- By making support and accommodation services more accessible for people who experience homelessness – by increasing outreach support
- By improving access to primary care, this will make MH support services more accessible to those who require them
- By supporting those living with dementia to access the right support in a way that suits them

Key programme features and milestones:

- Action plan development following Marmot Review
- Development of the MH primary care liaison model

Further transformation to be planned in this area:

- Over the next two years
  - Alignment to 15 minute neighbourhoods and locality hubs
  - X
- Over years three to five
  - X

Programme funding:

- Investment and Innovation Fund for 23/24
- CC2H business case

Leadership and governance arrangements:

- Waltham Forest MH Transformation Board – sub group of the Place Based Partnership Board
- Link to NEL MH LDA Board

Key delivery risks currently being mitigated:

- Workforce – issues in both MH and Primary Care
- Increased demand and acuity for services
- Ability to invest long term in areas that will reduce inequality whilst still trying to meet acute demand

Alignment to the integrated care strategy:

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

Standard template: transformation in NEL

North East London Health & Care Partnership

Workforce/ NEL / Francesca Okosi, Chief People & Culture Officer, NHS NEL, francesca.okosi@nhs.net

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

The transformation portfolio: digital infrastructure

North East London Health & Care Partnership

Level 0 – Infrastructure
Robust foundations and digital maturity

Major population growth of around 300,000 people over last 10 years with similar upward trend for the next 10 years, as well as the need to exploit new technology necessitates

- Maintaining a strategy of minimising the number of systems across NEL
  - Single appointment system across the 5 NHS Trusts to be considered
  - Moving towards a single provider of acute EPRs (£45m allocated for replacement of the EPR in BHRUT with Cerner Millennium)
  - Moving towards a single provider of General Practice Patient Record systems
  - Single provider of mental health systems (Access RiO)
  - Multiple community systems are in use across NHS and third sector providers
  - PCNs will use EMIS Clinical Services or TPP with Online Consultation tools to support Extended Services
- Key investments (£220m capital, £270m revenue over 5 years)
  - Circa £2.7m investment into Care Home and Home Care sectors to implement electronic care records
  - £43m for EPR developments across NEL, primarily BHRUT's move to Cerner Millennium and upgraded IT equipment which will:
    - improve accuracy of record keeping and recall within the trust, enabling patients to 'tell their story once'
    - enable efficient handovers and staff communication
    - promote ease of access to better co-ordinate care delivery
    - improve the availability, timeliness and quality of clinical data
    - support clinical decision making by reducing the need to check other systems for information
    - establish a patient record based on a single defined dataset, allowing better integration with specialist and partner organisations, e.g. creation of single acute specialty Patient Treatment Lists
  - Up to 6 Community Diagnostic Centres (two already open) to ease the burden on acute sites, increase overall capacity and provide more certainty for patients, who can undergo procedures in a more convenient environment
  - Maternity service digitisation (Homerton moving to Badgernet (£500k), others will evaluate and decide between it and Millennium) to improve information available to clinicians
  - Medium term move to cloud based telephony across primary care to facilitate collaboration across practices and PCNs
  - Implementation of shared digital image capture and real-time sharing to reduce unnecessary procedures after transfers and reduce storage costs
  - Network, cyber and end user device improvements (using VDI where practical) to improve staff experience and ease of access to information
  - Online registration for GP patients (complete)
  - Expanding the Electronic Prescription Service to outpatient services (£440k)
  - Change facilitators to support transformation of primary care services (£1.4m invested in 22/23)

The transformation portfolio: digital infrastructure

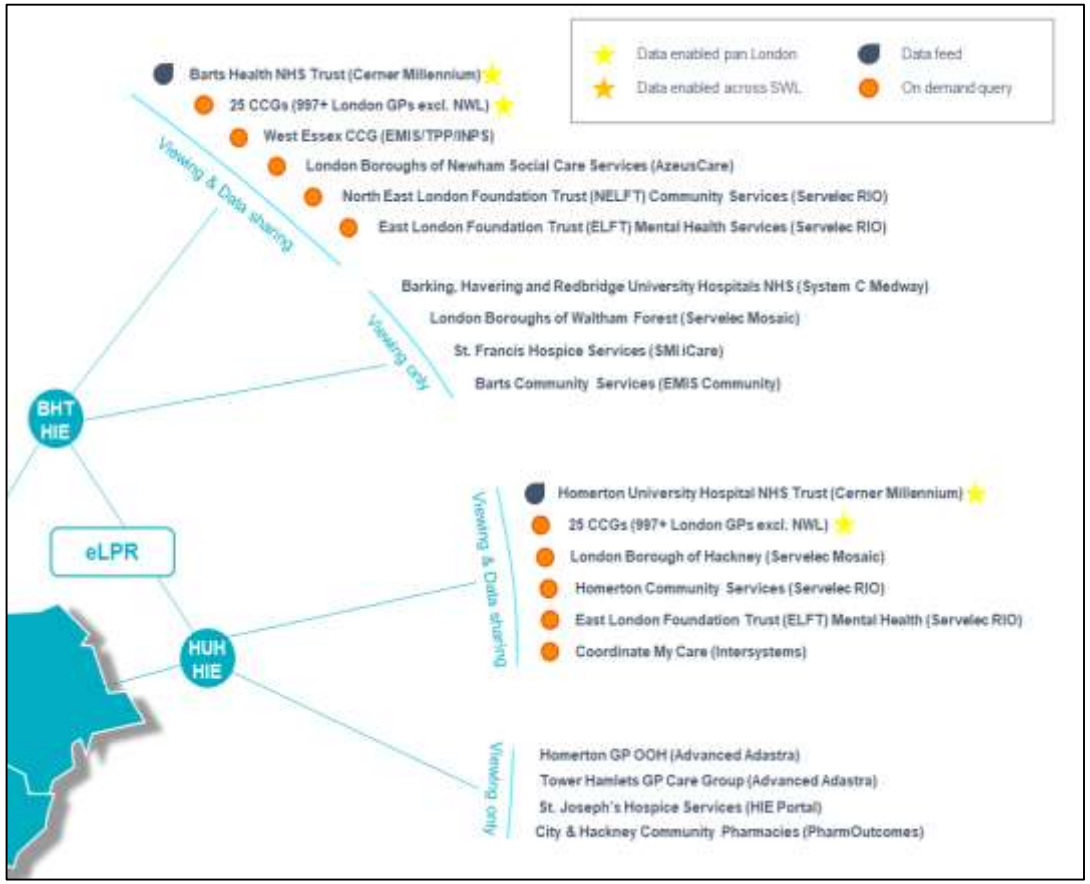
North East London Health & Care Partnership

Level 1 – Shared record
Single record

The vital importance of professionals having as complete a view of their patient's record as possible, means

- We will expand access to the Electronic Patient Record to:
  - the remaining social care providers
  - the remaining community pharmacists
  - all care homes with a secure electronic patient record systems (85% of Care Home providers are DSPT compliant)
  - the remaining community care providers with secure electronic patient record systems
  - independent sector providers with secure electronic patient record systems
  - the Joy social prescribing system currently being implemented in Newham and Barking and Dagenham.
- Key investments are needed (Total of £26m capital, £34m revenue over 5 years)
  - £2.5m invested for GP notes digitisation. Approximately £5m more required
  - £13m to improve the interoperability of systems in mental health and community and to support increased use by clinicians
  - £2.9m to complete the rollout of eLPR for BHRUT and three remaining Local Authorities

Access to east London Patient Record (eLPR) currently running at circa 350K views per month



east London Patient Record users, July 2022

The transformation portfolio: digital infrastructure

North East London Health & Care Partnership

Level 2 – Population Health / Advanced Analytics
Realtime information for proactive care
Leveraging population information

The use of advanced analytics and exploitation of the 'big data' that exists in NEL, is being, and will be, provided thus:

- Discovery Data Service (DDS) is now delivered in-house by NEL ICB and hosted for the NEL/NWL/SEL ICS collaborative
- NEL ICB will host the London Data Service, provide ICS partners with pan-London NHSD data sets and work with partners to develop a linked "data services layer" for all of London including acute, primary, community and social care data
- Implementation of the Cerner HealtheEDW in NEL will support professionals providing more proactive care to patients and contribute to a research data hub for London
- Further implementation of DDS Dashboards for Primary Care across NEL
- Utilise CORE25 plus 5 methodology to target and organise health and care interventions to improve outcomes, drive self care and reduce inequalities
- Rollout of the call/recall Active Patient Link tools for Childhood Immunisation and Atrial Fibrillation
- Key investments (£10.5m capital and £28.5m revenue over 5 years)
    - £14m for provision and future development of DDS
    - £6.5m in the data service within NEL to exploit DDS and other data sources
    - £5m within BHRUT for their internal data warehouse rebuild

The transformation portfolio: digital infrastructure

North East London Health & Care Partnership

Level 3 – Patient / resident engagement
Patient / resident empowerment

Improved resident and patient engagement will be achieved by

- Promotion of the NHSApp as the 'front door' to NHS services, including Patient Knows Best (PKB), primary care record, Online Consultations and ordering of repeat prescriptions
- Delivery of the Patient Held Record (PHR) PKB programme ('22-'24) to improve communication channels with patients and reduce unnecessary visits to hospital (Patient Initiated Follow Up)
- Greater use of online consultation tools in primary and secondary care to allow those that want to, to engage digitally and free up traditional channels for those that prefer to use them
- Management of Long Term Conditions in the home utilising remote care technology so reducing average length of stay and supporting people to remain in their own home rather than move to a care setting
- Co-production of digital solutions with end users, such as PKB
- Integration of physical health checks for residents with mental illness
- Further developing the Social Prescribing service by implementing Joy (initially in Barking & Dagenham and Newham)
- Increased use of digital tools to support elective recovery (including PIFU and advice & guidance) and reduced use of the unplanned health and care system
- Improving patient engagement further through digitisation in community pharmacy, care homes and domiciliary care providers

Much of this work will result in reducing the environmental impact of health and care services in line with the aims of the NELHCP Green Strategy

The transformation portfolio: physical infrastructure

North East London Health & Care Partnership

Standard template: transformation in NEL

North East London Health & Care Partnership

Critical Care / Acute Provider Collaborative / SRO: Simon Ashton, Chief Executive Officer, Barts Health simon.ashton@nhs.net

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

- April 2024:
  - Increased critical care capacity across the network (NUH, HUH, SBH)
  - Improved flow via joint working with the surge hub
  - Alignment of critical care outreach services across the network
  - Representing NEL patients at London and national forums to develop programmes
- April 2026:
  - Improved recruitment and retention of medical and nursing workforce
  - Improved access to specialist care
  - Equitable provision of follow up services across NEL which meet or exceed our London peers

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

- By 2026 patients will have equal access to specialist care, i.e. cardiogenic shock, and will be treated by a specialist team regardless of the hospital they present
- By 2028 patients will have access to a NEL specialist weaning centre, which will enable patients to receive weaning care in the local community, rather than having to travel out of the sector
- By 2026 patients will have equitable access to follow up services across NEL and in line with London, providing applicable patients with greater access to physical and psychological support following their admission in critical care.

Key programme features and milestones:

To develop a ratified strategy for adult critical care services across north-east London, develop a demand & capacity model that meets national Adult Critical Care network requirements and maximises potential opportunities to meet the future population needs and to develop and implement a medical workforce plan to support the current and future needs of critical care in NEL.

- Present final draft strategy to NEL Critical Care Board for approval and submission to APC (Dec 23)
- Agree standardised methodology and agree key data items and assumptions required to build capacity and demand model (Sept 23)
- Develop medical workforce strategy for NEL Critical Care Board approval (Oct 23)

Further transformation to be planned in this area:

- Over the next two years
  - Data sharing - patient records and operational information
  - NEL ACC Network website
  - Developing inter-site recruitment opportunities
- Over years three to five
  - Long term weaning centre
  - Renal enhanced care capacity
  - All units to work towards being GPICS compliant

Programme funding:

- 23/24: £250k – 67% funded via NHSE, remaining 33% to be funded by provider Trusts

Leadership and governance arrangements:

Programme lead: TBC

Programme overseen by NEL Critical Care Board and the SRO which reports to APC Executive Group.

Key delivery risks currently being mitigated:

1) Access to data - reliable data sources outside of critical care, i.e. population growth
2) Access to data across the APC provider Trusts
3) Resource – to enable delivery of the strategy and plan
4) Support at Trust level – would require agreement from all involved Trust
5) Trust integration – delivery will require integration of IT systems, and governance approach

Alignment to the integrated care strategy:

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

Standard template: transformation in NEL

North East London Health & Care Partnership

Research and clinical trials / Acute Provider Collaborative / SRO: Alistair Chesser a.chesser@nhs.net

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

- April 2024:
  - Increased and more equitable access to clinical trials across NEL
  - Research activity and clinical trials will cover a broader range of services
  - Increased patient and public involvement and engagement (PPIE) in clinical research
- April 2026:
  - Increased volume and quality of clinical research will support service quality improvement
  - Increased focus on research themes that address health needs and inequalities in NEL
  - Outputs from clinical trials and research activity will be applied to improve service delivery

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

- By April 2024: PPIE programme will be established to engage local communities in the development of clinical research strategies
- By April 2024: Clinical trial participation will be extended to currently under-represented communities and patient groups
- By April 2026: Increase in participation in research and clinical trials across all groups, and participation gap between different communities will be reduced compared with current baseline
- By April 2026: Clinical trials outputs will address specific health needs for currently under-represented communities

Key programme features and milestones:

Purpose: the development of a strategy and workplan for the co-ordination and development of research and clinical trials across North East London (NEL)

- Development of shared policies and processes (Jul 2023)
- Assess scope of current research inequalities and develop action plan (Jul 2023)
- Increase access to clinical research training (Dec 2023)
- Strengthen academic links between Trusts and academic partners (QMUL, UCL, City, UEL, Greenwich) (Dec 2023)
- Develop and implement NEL approach to research PPIE (Mar 2024)
- Improve clinical trial recruitment processes (Mar 2024)
- Increase clinical trial income from commercial and non-commercial studies (Apr 2024)

Further transformation to be planned in this area:

- Over the next two years
  - Multi-site clinical trials across NEL
  - Flexible use of clinical research resources across NEL
  - Integrated research skills training programmes
- Over years three to five
  - Clinical trials facilities at each hospital site
  - Primary care and mental health research facilities
  - Development of clinical academic centres of excellence

Programme funding: (Overall sum and source; breakdown across capital, workforce / care services, programme delivery) The programme resources are made up of personnel from the three trusts.

Leadership and governance arrangements:

Programme lead: Sven Bunn
Programme overseen by management group (PMG) which reports to APC Executive Group.
Working with LCRN and Trust Research Boards.

Key delivery risks currently being mitigated:

1) Overlap / conflicts with Trust level governance processes - Ensure specific role and tasks for the APC RCT workstream
2) Resource / time commitment - Clear work plan and outputs
3) Organisational commitment - Ensure alignment to strategic objectives

Alignment to the integrated care strategy:

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

Standard template: transformation in NEL

North East London Health & Care Partnership

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

The benefits that north east London's residents will experience by April 2024 and April 2026:

April 2024:

A greater involvement of joining up specialise services with pathways within NEL, via specialise services being delegated to NEL ICB. Improvements to residents includes:

- Renal - Improved access to home therapies - by 2024 there will be an Independent Therapies Centre at Mile End Hospital (and a young person's unit) and by 2024 a Mosque dialysis Unit will be in place. Currently achieving target of 20% dialysis patients on home therapy - 78 patients either having haemodialysis at home, or in training to do so, with plans to increase this number.
- Haematology - Residents with sickle cell will receive appropriate analgesia and other pain management measures (ideally within 30 minutes) when attending any acute A&E in NEL
- Paediatrics – reduce waiting times and address variation across sites for surgery in children by implementing GIRFT principles across NEL

April 2026:

- Specialise services proactively working as part of end to end pathway transformation approach, with a aim to reduce residents attending specialise service with preventable conditions by improving prevention programmes in NEL and haulting the progression on LTCs
- Neonatal – increase cot capacity in NEL, along with improved Enhancing the experience of families through care coordinators and embed Family Integrated Care in all units
- Cardiac – implement the Cardiac Pathway Improvement Programme which a aim to improve quality and safety of care across the pathway leading to better outcomes
- HIV – residents are 50% less likely to die as a result of HIV/AIDs

How this transformation programme reduces inequalities between north east London's residents and communities:

- Providing care closer to home and reducing unwarranted variation across London by implementing new models of care for L2 and L3 paediatric critical care
- Delivering the Cardiac Pathway Improvement Programme (CPIP) to reduced mortality due to cardiovascular disease by reducing variation in prevention, detection and management of CVD risks
- Hep C – We are working with the Hepatitis C Trust to identify disadvantaged and vulnerable groups are at risk of hepatitis C, such as people who are homeless, undocumented migrants and sex workers to provide different options for testing such as opt out testing in A&Es and work with local communities to reduce sigma and open up the conversation regarding support.
- By reducing unwarranted variation in access to specialist assessment & treatment within 24 hrs of symptom onset for NEL residents with TIA (current range between 40% for BHR to 92% for C&H residents)

Key programme features and milestones:

From April 2024, NHSE will be delegating responsibility and budgets to NEL ICB for a number of specialised services. The team will ensure robust infrastructure to optimise the benefits and manage the risks of delegation in the short, medium and longer term through end-to-end pathway redesign & LTC management closer to the patient's home. The programme provides the opportunity to co-produce new models of specialist clinical care with specialist clinicians, networks and service users, to improve outcomes for patients, including:

- Establish 8 Rapid Access Acute Rehabilitation beds at the Royal London to improve patient outcomes and experience and reduce overall length of hospital stay by Q1 23/24
- All acute hospitals will provide HIV and Hep C & B opt out blood tests to 90% of those who attend ED by Q2 23/24
- Dialysis & Home Therapies: Independent Therapies Centre (ITC) at Mile End Hospital (building complete Q3 23/24

Further transformation to be planned in this area:

- Delegation from 24/25 is planned for c 59 specialised service lines which will incrementally increase, annually, as NHSE deem an increased number of services as suitable for delegation.
- Short term delivery is based on the priorities described; medium term levelling up clinical outcomes will be through acute collaboration, whilst in the longer term, service consolidation will drive a reduction in clinical inequality.

Programme funding:

- The delegated budget is c £597m with the potential for a further £32m to be rapidly delegated.

Leadership and governance arrangements:

- Director Archna Mathur; Programme Director Charlotte Stone
- Oversight & Assurance framework for specialised services (NHSE) and NEL specialised Service Programme Board.

Key delivery risks currently being mitigated:

- Funding formula changes disproportionately impact NEL and population-based allocations impact cross-border flows however pace of convergence safeguards for year 1 provide a mitigation
- Resources to deliver the specialised services programme are a key risk as the delegation is not accompanied by NHSE resource. Resource mitigations are however in place with a resource plan submitted for iCB consideration,

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Lived Experience Leadership Programme / MHLDA Provider Collaborative / Carys Esseen, carys.esseen@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - 50 adult mental health service users and carers across NEL upskilled and trained to act as Lived Experience Leaders (LELs)
  - Lived Experience Leaders active in all aspects of the MHLDA collaborative
- April 2026:
  - 150 (cumulative) service users and carers trained as LELs (including U18s)
  - Lived experience leadership approach expanded to include people with learning disabilities and autistic people, with resources secured to support this expansion

How this transformation programme reduces inequalities between north east London's residents and communities:

- Mental health service users and carers are supported to develop their skills and confidence; improving their quality of life and helping them to work towards employment (where desired)
- The priorities of our service users and carers relate strongly to reducing inequalities, improving cultural competence, and improving access to services for people across NEL
- This programme will explicitly reach out to users of non-NHS mental health services and ensure they have the same access to development opportunities as those in secondary care
- Lived Experience Leaders will bring fresh perspectives and creative approaches to tackling the challenges we face, including reaching out to underserved populations and communities

Key programme features and milestones:

- By May 2023 we will have recruited to our brand new Lived Experience Leadership Team roles, which will be prioritised for people with current or recent experience of using mental health services and their carers
- In late-2023 we will have a follow-up Mental Health Summit to review progress and strategic priorities
- By December 2023 we will have initiated work to develop our Lived Experience Leadership Programme to include autistic people, people with learning disabilities and their carers
- By April 2024 we will be able to point to and measure specific service improvements or other demonstrable outputs from projects or initiatives that Lived Experience Leaders have been supported to lead

Further transformation to be planned in this area:

- Over the next two years
  - Develop an approach to building leadership capacity in children and young people
  - Learn what matters most to autistic people and people with learning disabilities and their carers
- Over years three to five
  - Expand Lived Experience Leadership Team capacity to cover all ages, and LD and Autism

Programme funding:

- £117,000 in 2023/24 from growth in MH funding
- Staffing costs - £97,000
- Sundry costs - £20,000

Leadership and governance arrangements:

- Support from MHLDA Collaborative Exec, and ELFT & NELFT Patient Experience / People Participation leads
- Reporting into the MHLDA Collaborative Committee

Key delivery risks currently being mitigated:

- There is a lack of capacity within ELFT, NELFT and the ICB to match the ambitions of our service users and carers. This has been mitigated through the identification of resource to fund and support this work.
- There is a risk that this work remains limited to adults with mental health needs, but once the posts (above) have been recruited to, there will be capacity to support people with LD and autism, and children and young people

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care		High-trust environment	x
Long-term conditions		Employment and workforce	x	Prevention		Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Learning Disability and Autism Improvement Programme / MHLDA Provider Collaborative / Pauline Goffin, Director of Mental Health, Learning Disabilities and Autism, NHS NEL, pauline.goffin@nelft.nhs.uk

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Adult inpatient numbers to be below 30 per 1,000,000 population across NEL
  - Child inpatient numbers to be below 15 per 1,000,000 population across NEL
  - 75% annual LD health check target met or exceeded in every borough
- April 2026:
  - A consistent crisis pathway to be in place for all children and young people
  - Improved reasonable adjustments in mainstream health services (LeDeR recommendations)
  - Equitable access to community health support across all seven boroughs for the LDA cohort

How this transformation programme reduces inequalities between north east London's residents and communities:

- By ensuring that all mainstream health services are able to provide reasonable adjustments and the same level of service for residents with a learning disability and autistic residents
- By supporting all residents to receive assessment and diagnosis promptly, along with the necessary support following diagnosis
- By having a crisis pathway in place for children, young adults and adults with a learning disability and autistic people that emphasises proactive, personalised, and preventative support in the community, from integrated teams that can wraparound individuals and their families / carers

Key programme features and milestones:

- Led by NEL LDA Improvement Programme in collaboration with places, with clinical leadership from ELFT, NELFT and place clinical leads
- Implementation and mobilisation of the NEL key working service for children and young people – June 2023
- Mobilisation of expanded ASD pathway – June 2023
- Development of NEL Intensive Support Teams (IST) for adults – April 2024
- Increase uptake of health checks in 14-17 year olds, and conclude ASD health check pilot – April 2024
- Address gaps in community provision for people with an LD, including access to therapies – April 2025
- Implementation of crisis pathway for children – April 2025
- Consistent offer for autistic people of all ages – April 2026

Further transformation to be planned in this area:

- Over the next two years
  - Inpatient care and crisis support
  - ASD diagnosis pathway
  - Improving quality and uptake of annual health checks
- Over years three to five
  - Parity in community health support
  - Support and therapies for autistic people of all ages
  - Further development of CYP crisis support

Programme funding:

- £4.5 mil via SDF and the LDA Pathway Fund in 2023/24

Leadership and governance arrangements:

- Led by the NEL LDA Improvement Programme and place-based teams
- Reporting into MHLDA Collaborative Committee and to place-based partnerships

Key delivery risks currently being mitigated:

- Lack of capacity within programme team and at place to deliver on these ambitions. It is hoped this will be mitigated through the ICB restructure programme
- Lack of consistent approach to coproduction – funding apportioned to deliver this in 2023/24
- Temporary closure of sole LD inpatient ward – to be mitigated by introduction of IST model

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce		Prevention		Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Ageing Well/ Barking and Dagenham Place / Sharon Morrow, Director of Partnership, Impact & Delivery Barking and Dagenham, NHS NEL sharon.morrow2@nhs.net

The benefits that Barking and Dagenham residents who require proactive care will experience by April 2024 and April 2029:

- April 2024:
  - Greater access to wider activities in communities to improve health & well being
  - Fewer exacerbations of ill health and a better quality of life
  - Some new models of care that have been co-designed with residents
- April 2029:
  - Fewer residents moving from moderate to severe frailty
  - A reduction in non-elective activity due to chronic ambulatory care sensitive conditions
  - Providing services and support for residents to prevent development of health conditions and understand when and how to access services for the assessment and management of long-term conditions.
  - Improving health and wellbeing for residents, particularly those with long term conditions

How this transformation programme reduces inequalities between north east London's residents and communities:

- By addressing the impact of the wider determinants if health in the development of the model of care
- By building trust with residents, connecting them to community support, and engaging the voluntary sector and residents in co-designing services around residents
- By delivering a better resident experience by ensuring residents receive integrated and personalised health in places they choose to access, resulting in a better quality of life
- By reducing avoidable exacerbation of physical and mental ill health, including in underserved groups.

Key programme features and milestones:

To develop a new model of care across health, care and the voluntary sector that supports individuals in achieving their biopsychosocial and clinical goals.
Programme objectives are:

- To develop an MDT approach for people with mild/moderate frailty and co-morbidities (Q3 23/24)
- To connect disjointed parts of the system together by integrating PCNs with the VCSE through and emerging locality leads model (Q2 23/24)
- To establish a high intensity user service that meets best practice guidance, focussing help for non-medical factors as well as poor physical & mental health (Q3 23/24)
- To support carers identification training and carers support in line with the actions outlined within the Carers Charter (Q1 23/24)

Further transformation to be planned in this area:

- Over the next two years
  - Accelerate integrated care delivery at neighbourhood and place by using PHM to drive tangible change
  - Review the social prescribing model to optimise impact and integration with VCSE
  - Develop greater use of technology to support people living at home
  - Ensuring more residents with health conditions are assessed, identified and provided with condition management as early as possible.
- Over years three to five
  - Explore opportunities for integrating community hubs into the model
  - Providing support to enable independent living
  - Strengthening the NHS response to identifying and addressing domestic abuse

Programme funding:

- Ageing Well funding TBC (network roles)
- Health inequalities funding (localities model)
- Business case to be developed for HIU service

Leadership and governance arrangements:

- B&D Partnership Board
- B&D Adults Delivery Group
- B&D Executive Steering Group

Key delivery risks currently being mitigated:

- Programme resource not yet aligned to delivery plan – this has been included in ICB restructure; interim project capacity being explored
- Analytics support for PHM and data sharing agreements to be agreed
- PCN engagement and capacity to expand MDT working:

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production		Learning system	X

Some Ageing Well funding is unallocated within the BCF

Transformation in NEL

North East London Health & Care Partnership

Healthier weight / London Borough of Barking and Dagenham Public Health / Dr Mike Brannan Mike.Brannan@lbbd.gov.uk

The benefits that Barking and Dagenham residents will experience by April 2024 and April 2028:

- April 2024:
  - Weight management services more tailored to needs and preferences of families
  - Improving coordination and coherence across workstreams and stakeholders
  - Development of a Tier 3 Weight Management Service pilot
- April 2028:
  - Integrated approach to healthier weight services that are appropriate and accessible
  - Greater promotion and access to healthier weight opportunities (e.g. physical activity, healthy diet)

How this transformation programme reduces inequalities between north east London's residents and communities:

- By ensuring those with an unhealthy weight are able to access support through weight management services that meet their needs and preferences
- By supporting and enabling more residents to consume a healthier diet (~1 in 2 adult residents not achieving '5 a day'; lowest in London)
- By supporting and enabling more residents to be more active (~1 in 2 adult residents not active enough for good health; second highest in London)
- By creating environments and opportunities to make healthy eating and regular physical activity the easy choice.

Key programme features and milestones:

Healthier weight requires action across the drivers of weight and their determinants, therefore work covers:

- *Assessment and weight awareness raising* - National Child Measurement Programme
- *Weight management services* - Tier 2 (0-5, 5-12, Adults), Tier 3 pilot (CYP; FY2023-25), CVD Prevention, NHS Digital weight management, Diabetes Prevention
- *Physical activity promotion* – Community programmes, Sport and leisure services, park services, Exercise on referral, School Games, Social Prescribing
- *Healthy diet promotion* – Food Education Partnership, Good Food Economy Action Plan
- *Healthier lifestyles* – Healthy schools programme, 0-19 Universal services, Holiday Activity & Food clubs, Eat Well, Live Well, Feel Great (SEND)

Further transformation to be planned in this area:

- Over the next two years
  - Expansion of whole systems approach across wider stakeholders
  - Better targeted/tailored and more integrated weight management services
- Over years three to five
  - Coherent approach to promoting healthier weight behaviours (activity, diet)

Programme funding:

- LBBD (Public Health Grant, Education)
- NEL ICB

Leadership and governance arrangements:

- B&D Partnership Board
- NCMP working Group
- BHR Health and Care Cabinet
- Whole Systems Approach to obesity working groups

Key delivery risks currently being mitigated:

- *Lack of coordination* – Greater collaborative working (e.g. NCMP working group) and cross promotion
- *Commercial determinants / obesogenic environment* – Focus on creating environments and opportunities to make healthier food and activity easier
- *Wider societal drivers (e.g. deprivation)* – Embed promotion and support for healthier weight behaviours across Place interventions

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health		Health inequalities	X	Personalised care		High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Stop Smoking service (specialist and pharmacies] / Barking and Dagenham Place / [SRO and email address TBC]

The benefits that Barking and Dagenham's residents will experience by April [2024] and April [2026]:

April 2024:
- Improve recording of ethnicity data to ensure more accurate data on smokers
- Increase number of quitters year on, particularly in BAME men
- Reduction in rates in women,
- Minimise proliferation of Shisha outlets & illegal tobacco sales
- Reduction in vaping and shisha use in young people

- April 2026:
  - Reduction in smoking attributable hospital admissions and mortality
  - Accessible evidence-based stop smoking services
  - Reduce Illicit tobacco sales and smoking in people with MH issues
  - Trust built with residents by co-designing services with the residents

How this transformation programme reduces inequalities between north east London's residents and communities:
- By 2024, increase access to smokers from all communities including BAME and males who have a higher smoking prevalence.
- By 2025 reduce smoking in women, especially in pregnancy hence improve the child's best start to life.

Key program features and milestones:
LBBD has an inhouse service delivered by Comsol:
Level 3 specialist stop smoking service. Target groups
• COPD patients
• Pregnant women and partners
• Patients with diagnosed mental health condition.
• Young smokers aged 12-15
• Routine and manual workers.
The service offers holistic support to residents addressing the wider determinants, behavioural support and pharmacotherapy. Training for pharmacies. Working with the targeted lung screening programme to reach more males.
Level 1: London digital smoking service.
Trading Standards Team: on illicit tobacco & shisha use.
Targeted Lung Health Programme: scans offered to residents aged 55-75 years who have ever smoked.

Further transformation to be planned in this area:
- Over the next two years
  - Work with schools to implement NICE guidance on School-based interventions & link in with Healthy Schools work
  - Joined up working approach with Trading Standards.
- Over years three to five:
  - Deliver system wide approach to improve access by exploiting place-based arrangements e.g. engaging community champions, voluntary sectors
  - Broader work with local key stakeholders to work on Smokefree places and NHS

Programme funding:
- Overall sum and source: £400k
- Breakdown across capital, workforce / care services, programme delivery:
- Workforce £206k/programme delivery 194k

Leadership and governance arrangements:
- Director of Public Health
- Director of Community Participation & Prevention
- NEL NHS Tobacco Treatment Program Steering Group

B&D Partnership Board

Key delivery risks currently being mitigated:
Tobacco Control Partnership (that set local priorities) ceased in 2018/2019 due to staff changes.

Mitigation: service has developed other partnerships: ComSol, NELFT mental health services, BHRUT maternity services, primary care and adults drug service.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Estates / Barking and Dagenham Place / [SRO and email address TBC]

The benefits that Barking and Dagenham residents who require proactive care will experience by April 2024 and April 2026:

- April 2024:
  - Improved access to a wider range of community diagnostics
  - Better access to primary and community care service through the Beam Park Health Centre
- April 2026:
  - Access to one stop shops for health and care through integrated hubs in the community
  - Access to an integrated community, leisure and health hub for residents in the Barking Riverside area; improved access to primary

How this transformation programme reduces inequalities between north east London's residents and communities:

- By improving access to services closer to home
- By increasing capacity for more flexible, integrated service provision which enables care co-ordination and multi-disciplinary working across health, care and the VCSE
- By delivering a better resident experience through person centred estate that meets the needs of local communities

Key programme features and milestones:

To develop Barking and Dagenham infrastructure plan that will enable the partnership to deliver levels and quality of health and wellbeing services from sufficiently located, sized, and equipped premises in the short, medium and longer term as the population grows. The programme includes:

- The development of a SOC for Barking Community Hospital and Town Centre
- The development of the Barking Riverside hub business case (NHS lease agreement Q3 23/24)
- Optimisation of Beam Park health centre estate (open spring 2024)
- Mobilisation of the new Community Diagnostic centre (Q3 23/24)

Further transformation to be planned in this area:

- Over the next two years
  - Procurement of the health centre at Barking Riverside
  - Infrastructure development to support neighbourhood networks/Fuller implementation
- Over years three to five
  - X
  - X

Programme funding:

- NHS capital funding
- Section 106 funding for health infrastructure

Leadership and governance arrangements:

- B&D Local Infrastructure Forum
- B&D Partnership Board

Key delivery risks currently being mitigated:

- There is insufficient internal resources to deliver the programme - business case for interim capacity to be developed
- Service models can't be agreed – ensure early involvement of clinical teams in the development
- Revenue to support new healthcare estate – work with the LA Regeneration and Planning teams to maximise the S106 contributions for health infrastructure

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Supporting our residents with Cost of Living pressures in City and Hackney /City and Hackney Place Based Partnership / Nina Griffith, Workstream Director, NHS NEL, nina.griffith@nhs.net

The benefits that City and Hackney residents will experience by April 2024 and April 2026:

- April 2024:
  - Easier access to services that can support people with cost of living pressures
  - Increased uptake of all benefits that are available to those individuals
  - Access to a wide range of vol sector support in the community
- April 2026:
  - Significant increase in proportion of benefits reaching eligible individuals
  - Residents that are struggling receive a proactive offer of support which meets their needs and supports them into a sustainable financial position
  - Fewer people becoming homeless

How this transformation programme reduces inequalities between north east London's residents and communities:

- By providing direct economic aid to people who are close to or living in poverty
- By preventing people from becoming homeless
- By supporting people who are most vulnerable to cost of living pressures because of existing health problems or disabilities

Key programme features and milestones:

- Hackney Money Hub fully mobilised and realising intended benefits – by Q2 23.24
- Sustainable model for money hub agreed - by end 23/24
- Food network and Advice networks well established across the borough – by Q2 23/24
- Learning from warm hubs taken forwards for future winters – Q2 23/24
- Ongoing programme of training to equip front line staff with key tools / support offers across all partners – Q2 23/24
- Clear framework / structure for neighbourhood based approach in place – end 23/24
- Broaden the approach to focus on employment – Q2 23/24

Further transformation to be planned in this area:

- Over the next two years
  - All staff equipped with tools to support residents with cost of living pressures
  - Outreach model that proactively provides support
  - Wide a range of support services in place
- Over years three to five
  - A range of easy to access and evidence based support offers that are fully integrated into our Neighbourhoods model and proactively outreach to those who need it most
  - Clear approach to support people into employment

Programme funding:

- Most of the funding is via existing service budgets.
- Some additional investment has been put in place:
  - £509k to fund the Money Hub- from S256 transformation monies
  - £50K to support our food networks from S256
  - Use of government benefits- including HSF

Leadership and governance arrangements:

- Cost of Living System group in place, led by Place Director. Reports into the Neighbourhoods Health and Care Board and the Hackney Corporate Leadership Team

Key delivery risks currently being mitigated:

- Money Hub is only funded via non recurrent funds
- Impact of cost of living far reaching and we have limited levers to support residents
- Fuel costs and inflation continue to rise
- Lack of sustainable funding for many of our voluntary sector partners

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	x	Health inequalities	x	Personalised care		High-trust environment	
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Population Health / City and Hackney Place Based Partnership / SRO is Sandra Husbands sandra.husbands@hackney.gov.uk. Operational leads: Anna Garner and Joia De Sa.

The benefits that City and Hackney's residents will experience by April 2024 and April 2026:

- April 2024:
  - Improved collection of inequalities data, enabling services to identify and tackle inequalities
  - Improved ability of services to tackle inequalities
- April 2026:
  - Services will recognise the need for support to be proportionate to need and thus services will be more accessible to those who need them.
  - Residents wider social needs will be identified and met via contact with and liaison between services.

How this transformation programme reduces inequalities between north east London's residents and communities:

- By Improving the ability of partners to use data to identify inequalities locally and put in place interventions to reduce these
- By Improving the ability of partners to include residents in identifying interventions to reduce inequalities – thus empowering residents and improving chances of these interventions being effective
- By Increasing focus on prevention and thus preventing ill-health for those with high needs (health and wider social)

Key programme big ticket items:

- Improving collection and use of equalities data across City and Hackney including development and implementation of an equalities data strategy.
- MATCH project (embedding health equity in City and Hackney) – development of package of support (tested with 6-7 areas) – using NEL inequalities funding (2022 round)
- Implementation of Prevention Investment Standard – increasing focus and resources to prevention across partners in C&H.

Leadership and governance arrangements:

- Population Health Hub planning board – chaired by Sandra Husbands as SRO
- Reporting to C&H PbP delivery group and Neighbourhood health and care board
- MATCH project steering group

Programme funding:

- £400K (from LBH Public Health) for staffing
- £1M for prevention project delivery

Key delivery risks currently being mitigated:

- Lack of capacity of partners to engage in population health planning or initiatives when focusing on waiting lists or other immediate capacity issues
- Lack of Population health hub team capacity to take on increased projects

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Standard template: transformation in NEL

North East London Health & Care Partnership

Neighbourhoods Programme / City and Hackney Place Based Partnership [hosted by Homerton Health Care] / Sadie King S.King33@nhs.net]

The benefits that City and Hackney residents will experience by April 2024 and April 2026:

April 2024:
- Residents feel understood, listened to and empowered to use their strengths
- Residents know where to go for help when they need it
- All residents feel that they have an accessible forum to have their voice heard in local service design or delivery

April 2026:
- Residents are more physically active and able to do the things they enjoy for longer
- Residents experience reduced loneliness and isolation
- Residents have the skills, knowledge and confidence to manage long term health conditions
- Residents are more socially connected
- Residents gain increased self-esteem and aspiration

How this transformation programme reduces inequalities between north east London's residents and communities:
- By embedding an anti racist mind set in service design and improvement (OD pilot in LTCs)
- By developing a network of community navigation that reaches groups that have experienced institutional discrimination
- By embedding skills and ways of working that puts resident voice at the centre of health and care provision
- By coproducing a personalised care approach
- By developing infrastructure and systems where community insights and population health data are used routinely to identify and address locally specific health inequalities

Key programme features and milestones:
- A new Proactive moderate frailty neighbourhood pathway
- Multi-Disciplinary Meetings for shared decision making for people living with complexity
- Neighbourhood Forums, and working groups bringing residents, voluntary and statutory sector together to share insights and find solutions to local health inequalities
- Community Navigation Networks
- A workforce development programme
- Key services structured around the 8 Neighbourhood geography: Community nursing, Adult Social Care, Community Pharmacy, Community mental health.
- Long term condition pathways development (Community Gynaecology)
- Outcomes Framework and Evaluation

Further transformation to be planned in this area:
- Over the next two years
  - Neighbourhoods local leadership infrastructure
  - Frailty pathways improvement from prevention to end of life.
  - Neighbourhoods Workforce development
- Over years three to five
  - Estates and IT enablement
  - LTCs pathways

Programme funding:
- Overall sum and source: currently 1 million £ per annum Better Care Fund
- Breakdown across capital, workforce / care services, programme delivery: All Programme Delivery.

Leadership and governance arrangements:
- City and Hackney Health and Care Board
- City and Hackney Neighbourhoods Health and Care Board
- City and Hackney Place Based Delivery Group
- Neighbourhoods Providers Alliance Group

Key delivery risks currently being mitigated:
- Workforce turnover
- Cost of living pressures on services

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care		High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care

Infrastructure and enablers / Havering place based partnership / Luke Burton, Borough Director, luke.burton1@nhs.net

The benefits that Havering residents will experience by April 2024 and April 2026:

April 2024:

- Have access to **Mental Health Practitioners** through their local Primary Care Network Team, providing low level mental health support, to support people to access early intervention and support, prior to requiring more intensive support for which they may not meet threshold
- Residents will have input into the all age **Learning Disability Strategy** for Havering which will be published by April 2024, with a clear action plan setting out how Learning Disability services in Havering will be improved over the next five years
- Benefit from a joined up approach to **Quality**, with Quality Improvement embedded in every part of the delivery of their care. A single Havering forum will have oversight of quality from a borough perspective, with a particular focus on the handovers between care to ensure that these are seamless and smooth, and to review and learn from times when this is not the case
- A comprehensive and joined up **vaccination and immunisation programme** that reaches out to local people to deliver vaccs and imms in the places that work best for them, and will deliver multiple inoculations at the same time, where it is possible to do so, ensuring that, particularly the most vulnerable, are vaccinated.
- The foundation of a **Population Health Management system** will enable all workstreams to embed proactive and anticipatory care, supporting earlier interventions to prevent deterioration and supporting local people to remain well at home for longer.
- The foundation for a more integrated approach to workforce recruitment and development will be in place, learning from the significant developments in the Care Sector to develop 'Passports' and online learning platforms, alongside innovative
- Use of **technology** to improve productivity of front line staff, particularly Health Care Assistants, will create capacity and identify deterioration early, improving outcomes for local people
- Development and roll out of a **single directory** for health, care and VCS services that everyone has access to will support right care, first time

April 2026:

- **Mental Health practitioners** and other staff within the Primary Care Networks will work as part of a virtual integrated multidisciplinary team, responding to the needs of local people, and providing them with comprehensive mental health support as soon as they need it
- The **Havering All Age Learning Disability Strategy Action plan**, embedded within the strategy, codeveloped with local people, community and voluntary sector leads and health and care staff will progress at pace, tangibly improving outcomes for those with Learning Disabilities in Havering
- A comprehensive and fully integrated approach to **Quality** will ensure that failures in care, and in particular in the transitions between care, are identified and learned from in a timely manner to prevent further occurrences. All staff, across health, care and the VCS will be aware of how to identify and escalate potential issues before they become a failure in care.
- A comprehensive and fully integrated vaccs and imms programme, that delivers interventions to local people in the places that they prefer, in a way and with messages that are meaningful to them, will ensure that a greater proportion of the population is protected.
- A comprehensive and data driven **population health insights platform** which brings together information from health and care, across primary and secondary care, will identify key areas where service improvement is required, and will also enable greater proactive care to take place. This will ensure that local people have services tailored to their needs, with enough capacity to be responsive, and will enable earlier intervention to support people to remain well, before their conditions exacerbate.
- Greater use of technology will significantly increase the productivity of front line staff, supporting local people to remain well for longer and preventing deterioration particularly in the community, catching it before it requires hospitalisation
- The **single directory**(Joy) will be fully developed and rolled out and recognised and used throughout the borough, supporting right care, first time.

How this transformation programme reduces inequalities between north east London's residents and communities:

- By ensuring that all groups of people, including those for whom English isn't a first language, or who may have previously been mistrustful of vaccinations or not able to access to the vaccination sites, are able to speak to a local vaccs and imms team, within their community, who is able to answer their questions and support them to have the vaccinations that will protect them from potentially harmful diseases.
- By ensuring that everyone, including staff, have access to an easy to use director of services, showing all of the support that is available to them in their local area. This is translatable into many languages, and with staff from health, care and the community and voluntary sector, and unpaid carers/family members able to access this information to support residents who are less able to use technology, all residents should benefit from this.
- By ensuring that those with a Learning Disability have a clear strategy and action improvement plan to address inequalities for this group of people, improving life expectancy and access to services, and supporting codesign of services that are meaningful to them to achieve the outcomes that they want

Key programme features and milestones:

Mental Health practitioners within PCNs:

- Work with NELFT to develop a comprehensive training and development programme and appropriate supervision for those working in these roles
- Support PCNs in Havering to recruit to the Mental Health Practitioner roles
- All Mental Health Practitioner roles in Havering to be recruited to, and working as a virtual team across all PCNs

Learning Disability Strategy:

- April 2023 Specification to be developed for the strategy development
- June 2023 Procurement process to identify support to develop the strategy from the Community and Voluntary Sector, working closely with local people
- From July/August 2023 identified CVS lead to take forward development of the strategy with local people, based on their needs and aspirations, alongside development of a clear improvement action plan

Further transformation to be planned in this area:

- Over the next two years
  - Development and promotion of the Joy app to build a comprehensive service directory in Havering that everyone has access to
  - Development of an all age LD strategy that is owned and taken forward by all partners in Havering
- Over years three to five
  - Implement and deliver the all age LD strategy action plan in Havering

Programme funding:

- Mental Health Practitioners to be recruited using ARRS funding with PCNs
- Places are awaiting confirmation from NHS NEL on the budgets for place, to take forward these projects in a sustainable way

Leadership and governance arrangements:

- Havering LD and Autism Working Group
- Havering Integrated Care Coordination and Social Prescribing Network
- Havering Quality Improvement Working Group

All of these groups feed into the Havering Place based Partnership Board

Key delivery risks currently being mitigated:

- Resource to deliver the initiatives is a significant risk until the ICB consultation is worked through and there is an established team at place. We are working to mitigate this, for example, there is currently no LD strategy for Havering, so we are going to work with the community and voluntary sector groups who support local people to develop the strategy, so that we have capacity to develop it, and so that they can truly own and shape it.
- The partnership is using funding from several sources to take forward our initiatives in 2023, but await confirmation of place budgets to take our programmes forward in a more sustainable, ongoing way
- Access to data, and data sharing continues to be a risk

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London

Building Community Resilience / Havering place based partnership / Luke Burton, Borough Director, luke.burton1@nhs.net

The benefits that Havering residents will experience by April 2024 and April 2026:

April 2024:

- Codesign of the all **age obesity strategy in Havering** and subsequent action plan, to create a healthier Havering (Havering currently has one of the most overweight populations in London), supporting people to remain well and healthier for London and signalling greater investment and focus on being active and promotion of healthier eating options across the borough to support local people to make healthier choices that will improve their wellbeing and ultimately, healthy life expectancy
- Codesign with local people and partners of an all **age Havering Carers strategy** and subsequent action plan, that will ensure that gaps in service provision and addressed, and unpaid carers are identified and supported, to prevent the deterioration of their wellbeing. This will be supported by **training for unpaid carers** via health inequalities monies in 2023 to equip them with the skills they need to fulfil their caring role
- Codesign with the VCSE and partners of the **Community Chest programme** via which £100,000 has been invested in 15 community and voluntary sector groups running initiatives to improve the wellbeing of local people, address the Core 20+5 Health Inequalities, and support social prescribing / Local Area Coordination.
- Core Connector programme – As the pilot site for NEL this truly place based initiative is intensely focused on addressing health inequalities in our most deprived area, Harold Hill (Gooshays ward). Volunteer Core Connectors have been recruited from the local community; the Core Connectors go out into the community and support local people, particularly those experiencing inequalities and barriers to accessing care and support, to get the information and support that they need. The programme is Havering is being identified as a gold standard for this nationally.
- A comprehensive approach to **supporting people to stay well at home**, with a wide range of initiatives to ensure that local people are supported in the community, without the need to be transferred to hospital, improving their journey and outcomes, and overall wellbeing. Targeted work to join up care being provided to **housebound** patients will allow patients and their families to be **better informed** about their care.
- Care Providers Voice are leading innovation in the Care sector aimed at improving the delivery of Domiciliary Care and Care in homes thus improving experience of care, and outcomes for local people and improving recruitment and retention of staff, through: Significant Seven training for Dom Care Staff and using technology to improve training and development and workforce placements, and enabling more flexible workforce models.

April 2026:

- Ongoing delivery of the Havering **All Age Obesity strategy** action plan will see significant improvements to the activity, and excess weight of local people. Local people will be able to have conversations with health, care and VCSE staff about the support available to them to help them become more active and to make healthier food choices, and will also be able to easily access this information themselves online. Their overall wellbeing, both physical and mental, will be improved, and the healthy life expectancy in Havering will improve.
- Ongoing delivery of the **Havering all age Carers Strategy** will see improvements in the number of people identifying as Carers and formally registering with the Havering Carers Hub. Through this, an increased number of people will access a Carers assessment, and receive the support and guidance that they need. This will improve the health and wellbeing of both informal Carers, and the people that they care for. There will be improvements to respite services, and care coordination to further support this.
- Subject to confirmation of ongoing funding, the **Core Connector programme** in Harold Hill will be expanded to other areas of the borough such as Rainham, where the population there will benefit
- Our **Care** workforce recruitment and retention will be significantly improved, with a comprehensive training and development programme for all paid carers in Havering, with career development pathways embedded such as Training Nurse Associates and AHP assistants, and comprehensive work with local schools to improve the pipeline of local people entering careers in care.
- Through our **supporting people to remain well at home** programme, we will see improvements in the number of people supported to remain well at home, improving outcomes for them and reducing pressure on the acute hospital so that if local people need emergency care, they are able to be seen more quickly.

How this transformation programme reduces inequalities between north east London's residents and communities:

- Core Connectors in Harold Hill are based directly in the community and providing outreach to groups who often feel marginalised by traditional methods of health and care delivery, including; being based in the heart of the community by the community pantry, speaking with local people who are relying on subsidised groceries, reaching out into the traveller community to support them to access health and care, directly reaching out to those who are 'housebound' in Harold Hill to ensure that they are getting the support and care that they need, and engaging directly with people struggling with their housing, and those who may be refuges, to support not just access to health, care and benefits, but working with them to address their wellbeing, and look at their future career prospects etc.
- The supporting people to stay well at home programme will ensure that local people, particularly those who may be housebound and have complex needs but may not necessarily be able to advocate for themselves, receive comprehensive support and care, and are able to stay at home/ in their preferred place of residence for as long as possible, without the need for unnecessary hospital admissions.
- Supporting paid carers to access comprehensive training, development and support, and have career development options, to improve their wellbeing, and recruitment and retention in this key work group

Key programme features and milestones:

- Develop the Havering All Age Carers Strategy: engagement and codesign with local people underway, 1-1 discussions and focus groups undertaken to understand what is most important to local people.
- Increase identification of carers in Havering. There are currently 1,700 people registered with the Carers hub, through which they can access an assessment and further support. We know that there are many more Carers than this in Havering (data request with primary care currently for the number of carers registered within their PCNs). Training that we are running in 2023 will be shared widely across the borough for unpaid Carers and encourage people to identify as a Carer, and sign up for further support.
- Obesity strategy workshops held, and significant engagement with partners and local people undertaken to develop the strategy, and subsequent action plan. Further development of the action plan and strategy, which will be launched later in 2023.
- Core Connector programme to continue to develop and embed, with feedback to the national team and sharing of the learning. Currently capturing information on the impact of the interventions.

Further transformation to be planned in this area:

- Over the next two years
  - Launch of the Havering all age Carers strategy
  - Launch of the Havering all age obesity strategy
  - Continuation of the Community Chest programme
- Over years three to five
  - Delivery of the Havering Carers strategy action plan
  - Delivery of the Havering Obesity strategy action plan
  - Robust programme of community chest funding and monitoring of impact

Programme funding: £747,000 Health Inequalities programme funding (2022/23)

- £100,000 will deliver the Community Chest programme
- £100,000 will support unpaid and informal carers
- £25,000 to deliver some of the initial initiatives in the Obesity strategy action plan
- £60,000 to deliver improvements to housebound patient care

Leadership and governance arrangements:

- Havering Core Connector Project Group
- Havering Carers Strategy Development working group
- Havering Obesity Strategy working group
- Havering Community Chest Programme Working Group

Key delivery risks currently being mitigated:

- Havering is underfunded in relation to public health funding and other funding such as the Grant to the Local Authority, which has not changed in 10 years and of which now 70% is spent on social care support; this is due to historical funding formulas which do not take into account the significantly changing demographics in Havering. This is a risk that could lead to the exacerbation of inequalities; partners continue to lobby for the changes in population to be taken into account when consideration is given to health inequalities funding, as an example.
- Resource to deliver the initiatives is a significant risk until the ICB consultation is worked through and there is an established team at place. Partners are working together to try to mitigate this.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

St George's Health and Wellbeing Hub / Havering place based partnership / Luke Burton, Borough Director, luke.burton1@nhs.net

The benefits that Barking & Dagenham, Havering and Redbridge residents will experience by April 2025

- Receive care for renal, outpatient, long term conditions, ulcers, speech and language therapy, access to diagnostics such as MRI, CT, X Ray and Ultrasound, dermatology, minor ops, early cancer detection and GP services at the new St Georges Health Hub Facility
- Access a larger emergency department at Queens hospital
- Be provided with community spaces and access to joint teams of health and social care professionals all in one place

How this transformation programme reduces inequalities between north east London's residents and communities:

- Supporting reduction of waiting lists for those in Outer NEL where waiting lists and care pressures are higher
- Allow more targeted holistic interventions of socially excluded groups such as older people and families in poverty
- Follow the equalities of funding agenda across NEL by providing needed local infrastructure
- Increase the support of children and families facing deprivation
- To use the integrated model to support vulnerable groups with holistic support such as benefits maximisation, housing support and the reduction in obesity

Key programme features and milestones:

- Start construction of St Georges Hospital – Enabling works August 2022, main construction to begin **Feb 2023**
- Complete construction – **May 2024**
- Formal opening of new St Georges Hospital Site – **Spring 2024**

Further transformation to be planned in this area:

- Over the next two years the St Georges Hub will be built and a number of the services above will be moved into or begin operating from the site
- Ongoing work with the local community to ensure the space is best utilised

Leadership and governance arrangements:

- St Georges Project Board reports into NELFT, BHRUT, Barts and NEL ICB statutory Boards

Programme funding:
£38.7m: Comprised of £17m from Wave 4 (b) funding, £968k from the sale of Elm Park, ICS allocation of £20.7M that is within operational capital envelopes

Key delivery risks currently being mitigated:

- Delays to construction planned start date
- Increased construction costs
- Workforce

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Living well / Havering place based partnership / Luke Burton, Borough Director, luke.burton1@nhs.net

The benefits that Havering residents will experience by April 2024

- April 2024:
  - Patients will be empowered to detect and manage cardio vascular disease risk factors such as hypertension, high BMI, high cholesterol, pre-diabetes and diabetes through the provision of POCT (**point of care testing equipment**) which will be deployed at three PCN (Primary Care Network) Hubs, all 10 Havering libraries and all phlebotomy sites, making access to such equipment easier
  - The provision of POCT equipment at the three PCN hubs will also reduce the need for patients to go for testing at other sites in the borough, as GP practices will have this testing ability on site, saving patients unnecessary journeys and time
  - Havering has been without a **stop smoking service** since 2015, about 20% of residents smoke – they will now have access to a new stop smoking service which will be available in local pharmacies throughout the most deprived parts of our borough, particularly in Rainham, Harold Hill and Romford.
  - Residents who have a **learning disability and/or mental health** will also be able to access a new **stop smoking service** tailored to their needs, this has been co-designed around their needs as traditional stop smoking pathways and environments do not work as well for those with mental health and/or learning disabilities
  - Residents who are rough sleeping, in temporary accommodation, asylum seekers and refugees will all have access to a new **mental health outreach service**

How this transformation programme reduces inequalities between north east London's residents and communities:

- Smokers have comparatively poorer health than non smokers, smoking is move prevalent in the more deprived wards – by locating the stop smoking services in the parts of Havering where both smoking and deprivation rates are high, this will help target the intervention at those who need it most so that they can stop smoking and move towards having equitable health outcomes in line with those from the least deprived parts of Havering
- Those who are rough sleeping, housed in temporary accommodation, seeking asylum or refugees have comparatively poor physical and mental health, subsequently they tend to be high users of health care services. Through offering bespoke services to their needs, their engagement with healthcare services will improve in order to prevent them presenting at crisis point.
- By locating point of care testing equipment around accessible community hubs such as libraries and PCN hubs in the most deprived parts of our borough, this improves the accessibility to prevention and detection services for those who would otherwise struggle to access this

Key programme features and milestones:

- Recruitment of mental health outreach nurses by July 2023
- Launch of mental health outreach service by August 2023
- Deployment of point of care testing equipment and launch of service by April 2023
- Launch of stop smoking service by March 2023
- Launch of stop smoking service for those with a learning disability and/or mental health by April 2023

Further transformation to be planned in this area:

Over the next two years

- Expansion of stop smoking services to other parts of the borough, increase in stop smoking offer
- Commissioning of additional outreach services for those rough sleeping, in temporary accommodation, asylum seekers and refugees
- Increasing the number and type of point of care testing equipment available

Programme funding:

- £747,500 from Health Inequalities fund
  - £40k – Point of care testing/self service health check offer
  - £150k – mental health outreach for homeless
  - £52.5k – stop smoking services

Leadership and governance arrangements:

- Havering Health Inequalities Leadership Group which accounts into the Havering Place Based Partnership Board

Key delivery risks currently being mitigated:

- Finance - Potentially reduced levels of Health Inequalities funding being received
- Workforce – both London Borough of Havering and ICB staff being significantly cut, capacity of workforce to deliver and potential for key staff delivering change being lost

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	

Transformation in NEL

North East London Health & Care Partnership

Ageing Well / Havering place based partnership / Luke Burton, Borough Director, luke.burton1@nhs.net

The benefits that Havering residents will experience by April 2024

Ageing well monies used to support people with the impact of the increases in cost of living, Havering partners have come together to **fund warm hub**s, for local people to access, in some of the most deprived areas of our boroughs. These ensure that people have a warm place to sit throughout the day during the colder months, with refreshments, activities focussed on improving wellbeing, and information and advice including; energy, benefits, housing, and health messages – NB there are no restrictions around age in terms of access to this support.

Cost of living payments innovatively directed to those with lifesaving technology at home, to support with the cost of running this to ensure that local people can continue to remain supported at home – NB there are no restrictions around age in terms of access to this support. The ageing well portfolio of projects includes the following (provision of warm hub spaces, provision of essential life critical apparatus to support living at home, recruitment of Age UK Navigators to guide people through the complex health and social care system , additional strength and balance classes to reduce the increasing number of hospital related falls activity, increasing the provision of reablement care hours and support available, provision of in reach reablement to hospital wards, grants to develop primary care network anticipatory care offers, increase the number of local area coordinators, British Red Cross will take residents from care homes to medical appointments reducing the pressure on care home staff, the issue of blue bands to care home patients with dementia to help hospital staff identify dementia patients and tailor care to their needs), these will all help:

- Provide vulnerable older people with safe, warm environments, improve connections for isolated individuals with the local community, provides funding towards energy bills to maintain 24 hr essential health apparatus for those struggling to afford the costs
- Promote better mobility and reduce falls
- Re-enable older peoples mobility and self-confidence post an urgent care episode or post discharge
- Keep older people well and safe at home
- Enable older people in care homes to attend medical appointments

How this transformation programme reduces inequalities between north east London's residents and communities:

- Reduces risk for frail older people living in the community
- Reduces isolation for older people
- Promotes independence for older people, enabling them to live in their community for longer
- By Identifying and targeting those with lifesaving equipment at home, and asking them to complete a short form to access an additional one off payment to help them to fund this (criteria dependant to ensure that it supports those in greatest need), we have been able to ensure that local people, particularly the most vulnerable, are able to continue to run lifesaving equipment at home. This payment was on top of other schemes aimed at supporting local people with the cost of living impact

Key programme features and milestones:

- Increase falls classed by 12 per month before Jun-23
- Open warm hubs – Jun-22
- Energy Payments for essential life critical apparatus go live – Feb-23
- Continue reablement hours levels through til Jun-24
- Launch reablement pilot – Mar-23
- Pilot proactive care MDT – Mar-23
- Blue Bands to be used in care homes from Mar-23
- Care Medical escorts – go live February 2023

Further transformation to be planned in this area:

- Over the next two years
  - Roll out of Proactive Care across all PCNs fully by early 2024/25
  - Sustainable reablement care hours to be system funded from Q2 2023/24

Leadership and governance arrangements:

- Reporting to the Place Based Partnership Board
- Havering Place Ageing Well Working Group

Programme funding:

- £1.5M Ageing Well - Non-Recurrent through the BCF sec 75 agreement

Key delivery risks currently being mitigated:

- Workforce Recruitment
- Project Management and PMO capacity

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care	✓	High-trust environment	
Long-term conditions	✓	Employment and workforce		Prevention	✓	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Newham Frailty Model / Newham Place-Based Partnership / [SRO and email address]

The benefits that Newham's residents will experience by April 2024:

- April 2024:
  - Holistic support offered to residents and carers to improve quality of life outcomes
  - Residents with frailty will be supported by the frailty MDT to achieve a set of coproduced and personalised goals
- April 2024:
  - Factors that contribute to resident A&E attendances and unplanned hospital admissions will be minimised
  - Factors that contribute to resident GP encounters will be minimised

How this transformation programme reduces inequalities between north east London's residents and communities:

- By ensuring that the cohort of residents identified and supported by the frailty MDT reflect our current demographic profile
- By bringing clinical and care professionals together to review resident cases with a holistic view e.g. the wider determinants of health

Key programme features and milestones:

- Anticipatory care / proactive care
- Geriatric assessment pathways
- Multi-disciplinary teams for frailty
  - Stratford PCN pilot project mobilised from May 2022 to February 2023
  - Midway review in October 2022
  - Evaluation of the pilot is expected to be delivered by March 2023 – the pilot evaluation will feed into the development of our local anticipatory care model
  - Rollout frailty MDT to other PCNs across Newham

Further transformation to be planned in this area:

- Over the next two years
  - Virtual wards for frailty
  - Falls pathway
  - Develop design principles for integrated frailty hub

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Frailty Model Working Group chaired by Dr Rehana Aslam (Clinical Lead for Frailty), which reports up to the Newham Ageing Well Joint Planning Group

Key delivery risks currently being mitigated:

- Funding beyond the frailty MDT pilot not secured
- No national guidance around proactive care
- Recent operating guidance indicates that DES funding for proactive care will not be included

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Newham Neighbourhood Model / Newham Place-Based Partnership / [SRO and email address]

The benefits that Newham's residents will experience by April 2024:

- April 2024:
  - Tailored Interventions and services according to prevalence across geographic area that are closer and more accessible to residents
  - Support the improvement in outcomes around LTCs and NCDs
- April 2024:
  - Residents are effectively supported around the wider determinants of their health and wellbeing in a holistic, strength-based and inclusive way

How this transformation programme reduces inequalities between north east London's residents and communities:

- By utilising population health data to analyse needs, trends and demographics, and develop new services based on local insights and intelligence
- By talking to residents to find out what type of services they would like in their area
- By tailoring services and information (translate flyers, bilingual sessions, online presence, whilst maintaining regular sessions in the community)
- By ensuring services and delivery is Accessible, Relevant and Trusted, to reduce health inequalities and support good health

Key programme features and milestones:

- To implement the requirements of Fuller Review.
- Neighbourhood pilot project taking place in the south-east of the borough ('Quadrant 4')
  - Join up with the LBN Healthier Lives Programme to test some of the neighbourhood ways of working across the categories of the programme:
    - Treating tobacco dependence service
    - Specialist all-age weight management and movement service
    - Community projects for health and wellbeing
    - Addressing resource inequality

Further transformation to be planned in this area:

- Over the next two years
  - Learn from test and learn approach and agree plan for further developing neighbourhood model.
  - Review LTC pathways for impact
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Neighbourhood Working Group chaired by Dr Scarlett Gard (Clinical Director for Docklands PCN), which reports up to the Newham Clinical and Care Professional Senate

Key delivery risks currently being mitigated:

- Aligning governance and current footprints for delivery of care / services across the various providers and organisations
- Identifying funding for priority neighbourhood programmes

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Newham Population Growth / Newham Place-Based Partnership / [SRO and email address]

The benefits that Newham's residents will experience by April 2024 and April 2026:

- April 2024:
  - An infrastructure plan for Newham built from the service delivery strategy, to enable the required population health service initiatives to improve health outcomes in the borough over a 20-year + time horizon
- April 2026:
  - High levels and quality of service delivered from sufficiently-sized and equipped premises as the population grows
  - X

How this transformation programme reduces inequalities between north east London's residents and communities:

- Ensure Newham system is best placed to deal with the challenge of future population growth
- By focussing on buildings that provide for the needs of the local population, offer appropriate capacity, access and a positive experience
- By focusing on prevention and early intervention as a Newham place system to support patients and residents access help as early as possible including from primary, community and VCSF sector

Key programme features and milestones:

- Secure project management support and design population growth priorities and programmes
- Establish the governance, including establishment of the Local Infrastructure Forum
- Continue to support the development of Well Newham including all age offer and social prescribing support that is readily available and acceptable

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Local Infrastructure Forum, which reports up to the Newham Health and Care Partnership Board
- The programme is also sponsored by the Newham Health and Wellbeing Board

Key delivery risks currently being mitigated:

- Level of change and transition within the system
- Programme management capacity and resources to develop SOC
- Alignment of timescales between various site programmes
- Availability of revenue and capacity to take forward recommendations within the SOC
- Customs House s106 funds of £7.5m allocated specifically to a new scheme in customs house redevelopment which currently does not have a confirmed service strategy for this location – both NHS and LA.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Learning Disabilities and Autism / Newham Place-Based Partnership / Richard Fradgley, Executive Director of Integration, ELFT rfradgley@nhs.net

The benefits that Newham's residents will experience by April 2024 and April 2026:

- April 2024:
  - Residents get the right help at the right time from the right people
  - Residents have a team around them who know their needs and their plans and work together to help them achieve them
- April 2024:
  - Carers are supported to have a life alongside and outside of their caring role
  - X
  - X

How this transformation programme reduces inequalities between north east London's residents and communities:

- By identifying and agreeing priorities that are locally focussed based on data and evidence
- By focussing on universal to specialist level of needs using population health management approaches
- By having a strengthened focus on equity, equality and challenging racism and all forms of discrimination
- By working with and across all system partners, with a strengthened focus on residents voice from the start of any project

Key programme features and milestones:

- April 2023 – Agree a small number of initial priorities for partners to work together to deliver better outcomes for residents, staff and the system
- Autism Diagnostic Service and Autism service mapping
- Independence to an Ordinary Life

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Learning Disabilities and Autism Joint Planning Group chaired by the Clinical Lead and LBN AD of Commissioning, which reports up to the Newham Health and Care Partnership Board and NEL MHLDA Committee

Key delivery risks currently being mitigated:

- X
- X

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Ageing Well / Newham Place-Based Partnership / Jason Strelitz, Director of Adult Social Care and Public Health, LBN jason.strelitz@newham.gov.uk

The benefits that Newham's residents will experience by April 2024 and April 2026:

- April 2024:
  - Residents are able to plan for their future care and after their death – ensuring their wishes are known and respected.
  - Residents receive safe, high-quality Health and Social Care as needed
  - Increase in the number of 'End of Life Care' residents who die in their preferred place of care and death.
  - Improved early identification of long-term conditions or disability, including frailty and dementia.

How this transformation programme reduces inequalities between north east London's residents and communities:

- By identifying and agreeing priorities that are locally focussed based on data and evidence
- By focussing on universal to specialist level of needs using population health management approaches
- By having a strengthened focus on equity, equality and challenging racism and all forms of discrimination
- By working with and across all system partners, with a strengthened focus on residents voice from the start of any project

Key programme features and milestones:

- April 2023 – Agree a small number of initial priorities for partners to work together to deliver better outcomes for residents, staff and the system
- Further develop our palliative and end of life care pathways to enable support where and when people wish
- Develop our falls services and support
- Roll out our frailty pilot with a focus on MDTs and delivery of virtual ward services
- Develop and deliver plans for intermediate and anticipatory Care
- Timely and accurate diagnosis of dementia, and improved pre and post diagnostic care

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Ageing Well Joint Planning Group chaired by the SRO, which reports up to the Newham Health and Care Partnership Board and Newham Ageing Well Strategy Delivery Board

Key delivery risks currently being mitigated:

- X
- X

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Primary Care / Newham Place-Based Partnership / Karen Livingstone, CEO, NHC karen.livingstone4@nhs.net and William Cunningham-Davis, Director of Primary Care, NEL william.cunningham-davis@nhs.net

The benefits that Newham's residents will experience by April 2024 and April 2026:

- April 2024:
  - X
  - X
  - X
- April 2026:
  - X
  - X
  - X

How this transformation programme reduces inequalities between north east London's residents and communities:

- By identifying and agreeing priorities that are locally focussed based on data and evidence
- By focussing on universal to specialist level of needs using population health management approaches
- By having a strengthened focus on equity, equality and challenging racism and all forms of discrimination
- By working with and across all system partners, with a strengthened focus on residents voice from the start of any project

Key programme features and milestones:

- April 2023 – Agree a small number of initial priorities for partners to work together to deliver better outcomes for residents, staff and the system
- Develop our Primary Care Strategy in line with the Fuller Report recommendations, ensuring swift access and continuity of care for different groups and needs
- Reduce variation in practice and outcomes especially in relation to Long Term Conditions

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- Overall sum and source:
- Breakdown across capital, workforce / care services, programme delivery

Leadership and governance arrangements:

- Newham Primary Care Planning Group chaired by the SROs, which reports up to the Newham Health and Care Partnership Board

Key delivery risks currently being mitigated:

- X
- X

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Health Inequalities / Redbridge Place / SRO: Tracy Rubery, Borough Director, NHS NEL (tracy.rubery@nhs.net)

The benefits that Redbridge residents will experience by April 2024 and 2029:
By 2024

Health Inequalities

- Improved trusted relationships with communities through **RCVS Health Buddies** – through outreach work and awareness sessions with residents
- **Health Engagement Bus** – By 2024 residents will have improved access and awareness to services such as Health Checks, Childhood immunisations, Sexual Health and Substance misuse interventions
- **Culturally specific engagement officers –** By 2024 the Roma community will feel more inclusive and have equitable access to mainstream health social care services.
- **Wearable Tech** – More residents will have the opportunity to access and use wearable tech alongside recognised interventions such as nutritional advice and physical activity programmes to tackle areas such as prediabetics, hypertension and mental health issues.
- **Childhood immunisation pilot –** Improved patient access by reviewing data and putting interventions in place, reviewing access, times and locations so routine imms can be done that suits parents.
- **Social Prescribing community chest** – improved awareness of health and social care services using local organisation/charities/faith leaders in settings that targets certain communities.
- responding to community intelligence, and promoting sustainable impact for communities and addressing key priority areas related to reducing health inequalities in underrepresented communities
- **Community Cash Fund and Insights** – By 2024 under represented communites,will have more represented acces to a range of local health services for example hospices, post Covid and mental health services.
- **Door to door engagement** – By 2024 under represented communities will feel more engaged and have equitable access to mainstream health and social care services, through raised awareness and targeted engagement.

How this transformation programme reduces inequalities between north east London's residents and communities:
Targeting specific populations within Redbridge to inform and address inequalities and access to services by underrepresented groups
Targeting the Roma communities to improve access and increase awareness on health
Targeting practices/PCNs with granular data profiles to identify proportionally higher numbers of people from specific ethnicities on their case lists to identify specific ethnicities who have markers for pre-diabetes
Targeted messaging to better support these communities and individuals in relation to our specific focused conditions and access to services

Key programme features and milestones:
Childhood IMMs Pilot - Project started in July 2022 with project group being established and project plan agreed. MOUs have been drafted and signed by all 42 practices.
Engagement – onboarding of staff to structure and finalising door process and expand network opportunities.
Healthwatch – number of events planned to engage with underrepresented communities in March. MH First Aid training events planned for March
Health Engagement Bus – planning for launch event and more services onboarding. Exploring venues with community networks

Further transformation to be planned in this area:

Depending on recurrent funding the plan is to build on current initiatives.

Programme funding:

£791,500 – NHS Health Inequalities

Leadership and governance arrangements:
SRO: Hilary Ross
Finance Lead: Julia Summers
Governance: NEL Health Inequalities Steering Group
Placed Based Partnership Board

Key delivery risks currently being mitigated:

- Risk of recurrent Funding going forward to further develop programmes
- Workforce recruitment to support the programme.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Accelerator Priorities / Redbridge Place based Partnership / Tracy Rubery, Borough Director (tracy.rubery@nhs.net)

The benefits that Redbridge residents will experience by April 2024 and 2029:

By 2024

Accelerator Programme:

- **Childhood Vaccination** – By 2024 residents will have a more co-ordinated communication approach from system partners with one message. .
- **Housing and Overcrowding**, - By 2024 residents will have more community space available for respite from overcrowding.
- Vulnerable residents will be discharged to a sfae and stable environment to support their recovery from hospital.
- **Mental Health** – By 2024 residents will have equitable access to low level mental health services and feeling reduced stigma.
- By 2024 a wider range of staff across the system will have had access to vital mental health support training.
- **MDT working** – By 2024 parents of children and family and carers of dementia patients will experience a more holistic care approach through the development of multi-disciplinary teams across system partners.

How this transformation programme reduces inequalities between north east London's residents and communities:

- Targeted initiatives that aim to engage underrepresented communities.
- Tackling stigma in communities to ensure equitable access for the whole population
- Through MDTs providing a holistic approach to care residents experiencing a one stop shop
- Supporting the most vulnerable with housing and overcrowding by providing a raft of different support

Key programme features and milestones:

- Develop integrated governance arrangements across partners.
- Set up a task and finish group with system partners to drive forward the MH and Paediatric agendas.
- Analyse local vaccination data across PCNs to understand where we need to focus vaccination programmes.
- Plan and set up a GP paediatric Hub that includes Acute, primary care, health visiting and Early years services.
- Develop proposals that will address the wider aspects of Housing and Overcrowding to support vulnerable communities.
- Develop an overcrowding information leaflet to share with residents at engagement events and via the Redbridge website.

Further transformation to be planned in this area:

- Develop strategy for every contact counts for paeds vaccinations by 2024.
- Supporting the delivery of the Suicide prevention strategy by 2024.
- Develop and deliver a MDT model for Dementia Care by 2025.

Programme funding:
No funding currently Identified

Leadership and governance arrangements:

Each Programme area has a designated SRO
Each programme has a Project Lead with support

Governance: Redbridge Placed Based Board

Key delivery risks currently being mitigated:

- Securing funding to deliver the required initiatives.
- Having sufficient workforce to lead on the range of schmes to deliver the overall objectives.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Development of Ilford Exchange Health and Care Centre / Redbridge Place based Partnership / Tracy Rubery, Borough Director (tracy.rubery@nhs.net)

The benefits that Redbridge residents will experience by April 2024 and 2029:

By 2024

- **Ilford Exchange Health and Care Centre**
- Expand capacity of 2 local GP Practices to accommodate the growing population
- Deliver a new Blood Test and Podiatry Service for local residents
- Deliver a Talking Therapies service in a central location
- Relocate Health And Social Service (HASS) services
- Relocate Health Visiting & School Nursing Services into the centre
- Deliver a Long Term Conditions (LTC) hub to include key conditions, e.g. diabetes, respiratory.

By 2029

How this transformation programme reduces inequalities between north east London's residents and communities:

- Ensure equitable access for all communities with care closer to home in a central location
- A flexible, modern space that can adapt to the changing needs of the population
- More space to allow existing health and care services within a two-mile radius to expand to support more patients
- More space to provide new health services not previously available in Ilford town centre
- A "one-stop-shop" where people can access more than one service in a single visit.
- NHS, social care and the voluntary sector working together to make patient care more joined up
- Ensure more of Ilford's diverse communities are able to access the health and care support services that they need

Key programme features and milestones:

- Set up governance arrangements to oversee the development and delivery of the new health and care centre.
- Review feedback from the extensive engagement exercise with local residents to ensure their views are incorporated into the development.
- Agree the range of services to be delivered from the new health and care centre.
- By April 2024 mobilise the services and have a grand opening.

Further transformation to be planned in this area:

- Evaluate service delivery of new centre
- Look at further opportunities- to introduce new services.

Programme funding:

TBC

Leadership and governance arrangements:

SROs: Adrian Loads, Tracy Rubery
Governance: NEL ICB, Redbridge Place, NELFT Executive, PCN Boards

Key delivery risks currently being mitigated:

- Risk of securing the funding from the system.
- Risk of recruiting the necessary workforce in time for opening.

Alignment to the integrated care strategy:

Babies, children, and young people	X	Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Living Well / Tower Hamlets / Warwick Tomsett - Warwick.Tomsett@towerhamlets.gov.uk

The benefits that Tower Hamlets residents will experience by April 2024

- Strengthened Locality & PCN structures which are better able to locally identify and address health inequalities
- Improved pathways between communities and long term conditions services to better prevent and manage long term conditions
- More engagement with local communities to involve them in how services to improve their health and wellbeing are developed
- Improved access to health and care services for residents with disabilities

How this transformation programme reduces inequalities between north east London's residents and communities:

- By improving access to health and care services for residents with disabilities
- By preventing **long term conditions** and improving outcomes, including focusing on groups where LTCs may be more prevalent than others

Key programme features and milestones:

- Strengthening locality and PCN structures will involve working with our 4 locality committees to understand their population and deliver work accordingly and to work with PCNs to improve health inequalities through co-production and greater links with pharmacies
- LTCs prevention and management will feature improved pathways for links to health services after detection, improved prevention pathways for those at LTC risk
- Improving access to health and care services for residents with disabilities will involve building on the current pilot in 2 GP surgeries by extending this to other key services across all of our partners

Further transformation to be planned in this area:

- Over the next two years
  - Detailed project output with focus on PCN and locality approach
  - Further scoping of long term conditions priorities
- Over years three to five
  - Transformation plans to be confirmed i.e. phasing, scope and milestones

Programme funding:

- Public Health Grants
- Health Inequalities Funding
- Core based funding from LBTH and ICB
- Better Care Funds (BCF)

Leadership and governance arrangements:

- Principal strategic and operational oversight by Living Well Board
- Monthly delivery oversight by Local Delivery Board
- Quarterly assurance monitoring at THT Executive Board

Key delivery risks currently being mitigated:

- Limited data and data insights to determine activities, trends and population health management approach
- Gap on LTC lead in Tower hamlets

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care		High-trust environment	X
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Promoting Independence / Warwick Tomsett - Warwick.Tomsett@towerhamlets.gov.uk

The benefits that Tower Hamlets residents will experience by April 2024

- More effective and efficient discharge process from hospital to care at home and in the community
- A joined up approach to providing better, more holistic support for those who are homeless
- A joined up approach to providing better, more holistic support for residents with frailty
- Clear outcome-based framework and better experience for residents in the homecare
- More personalised and support care plan to be offered across residents to reduce long term resilience on care and improve overall wellbeing

How this transformation programme reduces inequalities between north east London's residents and communities:

- By improving outcomes for those who are **homeless**, who often experience some of the worst outcomes of any residents
- By accelerating the proactive approach and using population health management to identify residents who are **at risk of crisis** (anticipatory care)
- The use of cutting-edge approach to care coordination MDT and utilise health, care and other sectors to support **frailty** residents to be independent in the community

Key programme features and milestones:

- Joining up support services for homeless people will look to introduce a MDT care co-ordination pilot with key partners and service users to co-produce a new model of working **(June 2023 to May 2024)**
- Discharge to assess: TBD
- Joining up support for residents with frailty will seek to extend the current pilot in one PCN to further areas and embed the learning that has so far resulted **(May 2023 to April 2024)**
- Developing a new model of homecare will be an opportunity for us to use the re-procurement of the LBTH contract to identify and implement joint ways of working with health and community and voluntary partners to make the offer more holistic and improve outcomes for service users requiring care at home

Further transformation to be planned in this area:

- Over the next two years
  - Cohort Analysis (review) to determine further scope of work
  - Neighbourhood Approach in response to Fuller
  - Implementation of Frailty Care Coordination across all PCNs
- Over years three to five
  - Further review of programmes to determine additional work

Programme funding:

- Ageing Well, Better Care Fund, NEL Diabetes Partnership
- Personalisation - Personal Health Budgets
- Health Inequalities Funding
- Core based funding from LBTH and ICB

Leadership and governance arrangements:

- Principal strategic and operational oversight by Promoting Independence Board
- Monthly delivery oversight by Local Delivery Board
- Quarterly assurance monitoring at THT Executive Board

Key delivery risks currently being mitigated:

- Projects that do not have recurrent funding and risk of it being unable to continue to deliver
- Funding
- Recruitment – challenges to recruit roles specific to projects and transformations

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce		Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Centre of Excellence / Waltham Forest Place-Based Partnership / Sue Boon, Director of Delivery sue.boon@nelft.nhs.uk]

The benefits that Waltham Forest residents will experience by April 2024 and April 2026:

- April 2024:
  - Comprehensive, holistic support to manage complex care needs, including those residents with long term conditions
  - Access to virtual consultations with a range of specialists
  - Remote monitoring support, promoting resident impendence, through telehealth & telecare alignment
- April 2026:
  - Access to Wellbeing Lounge to support staying well for longer
  - Demonstrable reduction in A&E admissions, non-elective activity and bed days
  - Access to point of care testing

How this transformation programme reduces inequalities between north east London's residents and communities:

- By providing equity of access into the Centre of Excellence through clearly defined referral pathways
- By providing digital connectivity and capability to provide access to virtual services to all residents
- By considered estates planning through the programme executive to ensure the Centre of Excellence is delivered in a way which promotes equal access for all
- By providing proactive personalised care planning for those with complex health conditions

Key programme features and milestones:

- Digital Hub Virtual Remote Monitoring – launched for care homes Aug 2022. Nursing home focus in Q1 2023/24.
- Long Term Conditions (LTC) Hub/ Complexity Hub (holistic, specialist care for complex residents with LTCs) - to go live early 2023/24 as a virtual service offer
- LTC / Complexity Hub – face-to-face service offer by end of 2023/24
- Digital Hub Population Health Management – proactive data-based identification of residents who would benefit from early intervention – risk stratification tool to be developed and embedded during 2023/24
- Wellbeing Lounge (access to wellbeing services, VCSE, relaxation zone) – planning to commence in 2023/24
- Leadership, Innovation & Training Hub (staff training catalogue, portfolio careers, carers support, organisational development tools) – planning to commence in 2023/24

Further transformation to be planned in this area:

- Over the next two years
  - X
  - X
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

- £9m - Section 256 funding (5 year programme)

	Year 1 (22/23)	Year 2 (23/24)	Year 3 (24/25)	Year 4 (25/26)	Year 5 (26/27)
£000s Spend	£335	£1,263	£2,101	£2,359	£2,935

Leadership and governance arrangements:

- Waltham Forest Health & Care Partnership Board
- Centre of Excellence Executive Group

Key delivery risks currently being mitigated:

- There is a risk that we will not deliver the business case for community health service transformation and not deliver the reductions in acute admissions required to support a new WX hospital
- There is a risk that appropriate estates will not be available when required which will impact on the type of service being delivered

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Care Closer To Home Programme/ Waltham Forest Place-based Partnership / Sue Boon- sue.boon@nelft.nhs.uk

The benefits that Waltham Forest residents will experience by April [2024] and April [2026]:

- April 2024:
  - Proactive identification and early intervention, delivering a neighbourhood health and care model that integrates and improves community care for all residents.
  - Improved anticipatory care planning that reduces hospital admissions
  - Reduced number of emergency hospital admissions and days spent in hospital
  - Improved health and social care outcomes through personalised rehabilitation, reablement and recovery support
- April 2026:
  - Early coordinated support, joint decision making and personalised care plans in place for those who are most likely to use hospital services.
  - Care Professionals working in partnership with each other and with the residents for aspects which require support, e.g. physical, mental health, social care needs, housing and financial issues.
  - Fewer people requiring emergency hospital admission
  - Improved access to services for patients with low level mental health issues

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing the immediate and medium-term impact of a non-elective hospital admission, helping people to access services closer to home
- By reducing the prevalence and impact of long term conditions on residents
- By providing proactive personalised care planning for those with complex health conditions
- By improving interventions and outcomes for those with long term conditions
- By integrating intermediate care services to improved accessibility and rehabilitative outcomes for residents

Key programme features and milestones:

- **Care home multi-agency response** - Enhanced MDT response to care home including MDT meetings
- **Multi-disciplinary working at PCN level** - Proactive case finding/MDT care planning for those at high/medium risk of a hospital admission.
- **Complex LTC management** - Co-design of clinical pathways for priority long term conditions e.g. respiratory, cardiovascular, diabetes in line with population health needs across the borough.
- **Primary care–led MH liaison** - Establish enhanced mental health pathways within primary care.
- **Enhanced domiciliary care support** - Recommissioning reablement to support greater number of home discharges, improve independence post discharge and to prevent hospital admission – likely to be delivered under the Home First Programme

Further transformation to be planned in this area:

- Over the next two years
  - All 15 Care / Nursing Homes undertaking monthly MDTs
  - Multidisciplinary working across all PCNs
  - Enhanced pathways to the top 3 disease prevalent conditions in WF
- Over years three to five
  - Multidisciplinary working across all stakeholders
  - Personalised care planning for patients at risk of hospital admission

Programme funding: - Approx. £2,106k over 5 years

Impact over 5 Years:

CC2H - Proactive Anticipatory Care	Non elective admission reduction	317	714	1,121	1,129	1,137
	Bed days saved	1,534	3,355	4,249	4,277	4,306
	Beds saved	4	10	12	13	13
	£'000 saved	£784	£1,732	£2,713	£2,731	£2,750

Leadership and governance arrangements:

- Waltham Forest Health & Care Partnership Board
- Care Closer to Home Executive
- Care Closer to Home Operational Leadership Group

Key delivery risks currently being mitigated:

- If a risk stratification criteria / tool is not in place, it will put more pressure on GP time to identify the appropriate patients to be discussed at the anticipatory MDT. Engaging with NEL Population Management Team to resolve this.
- Anticipatory MDTs rely on full participation of PCNs. If additional funding is not made available, this will impact the level of resources needed to support the programme. Working with Primary Care and the LMC to agree SNS with PCNs.
- There is risk of not accurately monitoring patient journey due to incomplete data from GP practices/PCN that cover Care/Nursing Homes.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Home First Programme/ Waltham Forest Place-based Partnership / Sue Boon- sue.boon@nelft.nhs.uk

The benefits that Waltham Forest residents will experience by April [2024] and April [2026]:

- April 2024:
  - Improved urgent care support at home that reduces the need to be conveyed to hospital
  - Reduced number of emergency hospital admissions and days spent in hospital
  - Earlier supported discharge home with appropriate support such as virtual ward/hospital at home
  - Reduction in delayed discharge through a discharge to assess model and transfer of care hub
  - Improved health and social care outcomes through personalised rehabilitation, reablement and recovery support
  - Improved resident and carers experience through meaningful engagement and a continuous learning culture
- April 2026:
  - Seamless health and care support through an integrated intermediate care service
  - Fewer people requiring emergency hospital admission and long-term adult social care support
  - Improved access to community therapy to support rehabilitation goals and outcomes
  - Greater number of services such as diagnostics delivered within people's neighbourhoods
  - Increased use of voluntary and community groups, organisations and services to support people during and after intermediate care and support

How this transformation programme reduces inequalities between north east London's residents and communities:

- By reducing the immediate and medium-term impact of a non-elective hospital admission, helping people to rehabilitate and recover through a therapeutic-led care approach
- By providing proactive personalised care and support to help people regain their independence, confidence and ability to manage their own care and support at home
- By supporting carers and wider family networks to ensure people can stay at home in their communities for longer
- By reducing the likelihood of premature admission to residential care
- By ensuring people can access the appropriate health and care services in their neighbourhood (15 minute neighbourhoods) informed by the Marmot work in LBWF on health inequalities
- Through pro-actively connecting people with appropriate services once their intermediate care and support ends for example to voluntary and wellbeing services

Key programme features and milestones:

- **Discharge to Assess**
  Direct engagement in pre-discharge planning for residents and carers based on Home First principles
  Early supported discharge from hospital
  Care management and continued support post discharge for up to 6 weeks
  Access to specialist care and support in hospital and post discharge e.g. stroke
- **Rehabilitation, Reablement and Recovery**
  Dedicated in-patient rehabilitation outside of hospital#
  Therapeutic-led care approach to regain independence
  Access to appropriate assistive technology, aids and adaptations
  Free personalised reablement care and support for up to 6 weeks
- **Virtual Ward**
  Earlier discharge and admission avoidance through Clinician-led support Virtual Remote Monitoring
  Coordinated health and social care support for up to 14 days post discharge
- **Admission Avoidance**
  Coordinated assessment and referral for urgent care in the community
  2 hour response time for urgent care needs
  Care and support at home or in a step-up community bed to avoid admission

Further transformation to be planned in this area:

- Over the next two years
  - Increase of 27 WTE staff working in intermediate care
  - Increase of £1,681k of funding to support transformation
  - Aligning Home First with the IDF
  - Alignment to LBWF transformation i.e. 15 minutes neighbourhoods, Marmot review on health inequalities and Adult Social Care Reform
- Over years three to five
  - Increase of 39 WTE staff working in intermediate care
  - Increase of £2,426k of funding to support transformation

Programme funding: -£2,426k over 5 years

Impact over 5 Years:

Home First	Non elective admission reduction	389	779	1,168	1,168	1,168
	Bed days saved	3,276	5,995	8,714	8,714	8,714
	Beds saved	9	16	24	24	24
	£'000 saved	£1,624	£3,084	£4,544	£4,544	£4,544

Leadership and governance arrangements:

- Waltham Forest Health & Care Partnership Board
- Home First Executive
- Home First Operational Leadership Group

Key delivery risks currently being mitigated:

- There is a risk that if we are unable to continue to fund our discharge programmes that support the HF programme, then this will have a significant impact on ability to discharge people from hospital in a timely manner. Partnership discussions on funding for 2023/24. Likely Government will continue discharge support.
- There is a risk that we fail to engage staff in wider transformation and as a result we fail to deliver the new ways of system working. In 2023/24 both informal and formal engagement with staff will be a key focus as we further integrate teams and services

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	X	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	X	Employment and workforce	X	Prevention	X	Co-production	X	Learning system	X

Transformation in NEL

North East London Health & Care Partnership

Learning Disabilities and Autism / Waltham Forest Place-based Partnership / Sue Boon- sue.boon@nelft.nhs.uk

The benefits that Waltham Forest residents will experience by April 2024 and April 2026:

- April 2024:
  - Increased uptake of vaccinations amongst the population who have LD
  - Increased numbers of people with LD in employment
  - Reduced waiting lists for autism and ADHD in adults
  - Improved quality of annual health checks for people with LD
- April 2026:
  - Waltham Forest will be an Autism Friendly Borough and improved neurodiversity offer
  - Increased access to accommodation for people with LD and Autism

How this transformation programme reduces inequalities between north east London's residents and communities:

- By increasing uptake of vaccination for people with LD
- By improving quality of AHCs, we will reduce inequalities by identifying ill health earlier in this population
- By improving access to employment, this will improve the health, particularly MH, of this population
- By linking with the evidence and action plan of the Marmot Review

Key programme features and milestones:

- Specialist employment advisor for people with LD in post
- Specialist LD nurse for health inequalities in post
- Autism Strategy
  - Improving awareness and understanding of reasonable adaptations (inc. built environment)
  - Reviewing Education offer and support
  - Improving community safety
  - Targeting specialist training across health and social care

Further transformation to be planned in this area:

- Over the next two years
  - Link to 15 minute neighbourhoods
  - X
  - X
- Over years three to five
  - X
  - X

Programme funding:

- NEL LDA programme funding (as devolved to place)
- Investment and Innovation Funding for 23/24

Leadership and governance arrangements:

- Improving Life Chances Board
- Place Based Partnership Board
- Autism Strategy Board

Key delivery risks currently being mitigated:

- Workforce – issues in both MH and Primary Care
- Increased demand and acuity for services
- Ability to invest long term in areas that will reduce inequality whilst still trying to meet acute demand
- Lack of perceived priority by wider programmes often mean health inequalities are exacerbated and don't get prioritised

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Standard template: transformation in NEL - Wellbeing

North East London Health & Care Partnership

Wellbeing / Waltham Forest Places-based Partnership / Sue Boon- sue.boon@nelft.nhs.uk

The benefits that Waltham Forest residents will experience by April 2024 and April 2026:

- April 2024
- Increased access to information and advice
- April 2026 :
  - Reduction in health inequalities
  - Increased independence and feelings of wellbeing
  - Increased numbers of people playing active roles in their neighbourhoods

How this transformation programme reduces inequalities between north east London's residents and communities:

- We will use the Marmot research to understand the social determinates of health inequalities and develop solutions to address them
- We will use the data and insights gathered from communities to develop local networks and solutions to the issues that affect them.

Key programme features and milestones:

Understanding the needs of our population using :
- Population Health Management
- Community Insights
- !5 minute neighbourhoods

Providing Information, Advice and Guidance:
- Universal and Targeted
- Digital
- Face 2 Face
- Telephone
- Social prescribing

Health Promotion, Lifestyles and self care:
- Smoking Cessation
- Healthy Weight
- Others

Further transformation to be planned in this area:

- Over the next two years
  - Development of our assistive technology offer
  -
  - X
- Over years three to five
  - X
  - X
  - X

Programme funding:

Health inequalities funding

Leadership and governance arrangements:

Establishing a local programme group which will feed into the Place based partnership board

Key delivery risks currently being mitigated:

There is a risk that we will not be able to shift resources from acute services into preventative solutions that promote wellbeing whist still being able to meet acute system demands

Alignment to the Integrate care strategy:

Babies, children, and young people		Mental health		Health inequalities	X	Personalised care	x	High-trust environment	X
Long-term conditions		Employment and workforce	x	Prevention	x	Co-production	X	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

NEL NHS Tobacco Dependence Treatment Programme / Strategy and Transformation / Hilary Ross, Director of Strategy, NHS NEL, hilary.ross1@nhs.net

The benefits that North East London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Improved access to stop smoking support through all trust inpatient and maternity settings.
  - new services supporting thousands of inpatients to stop smoking
  - Decreased risk of miscarriages for our residents.
- April 2026:
  - 100% inpatients and pregnant people attending trusts in NEL have smoking status recorded and offered accessible and effective support to help them to quit smoking.
  - Reduction in smoking related readmissions at 30-days by 12% from baseline.
  - Reduction in smoking at time of delivery.
  - Reduction in the number of miscarriages, stillbirths and other birthing complications.

How this transformation programme reduces inequalities between North East London's residents and communities:

- Adult smoking rates are high across most boroughs in NEL compared to England. Smoking accounts for half the difference in life expectancy nationally between richest and poorest, and is particularly prevalent in groups such as routine and manual workers and people with SMI. Action on tobacco will have a direct impact on reducing health inequalities in NEL.
- Providing support to 100% secondary care inpatients will capture groups that may be less likely to seek out services, such as patients who are homeless, increasing their access to stop smoking support.
- Providing support to pregnant people to quit smoking will reduce health inequalities, including inequalities in stillbirths and infant deaths, and longer term health outcomes for mother and child.

Key programme features and milestones:

- All trusts providing tobacco dependence treatment services to 100% of inpatients, which will lead to improved outcomes.
- All maternity services supporting pregnant people to become and remain Smokefree, whilst undertaking CO monitoring at all appointments.
- Develop robust patient pathways with community partners.
- All trusts recruit staff members into roles dedicated to delivering inhouse tobacco dependence treatment services.
- All trusts to establish Smokefree Committees and smoking in pregnancy meetings.
- All trusts to evaluate their services.

Further transformation to be planned in this area:

- Over the next two years:
  - Ensuring tobacco dependence services in trusts become business as usual (sustainable).
  - Tobacco dependence services supporting community SMI service users.
- Over years three to five:
  - Smoking prevalence decreasing in each borough, moving towards <5%.
  - Developing opportunities for building brief interventions and tobacco dependence treatment into pathways across NEL, through collaborations across local authorities, trust, primary care and ICB teams.

Programme funding:

- 22/23 £947k NHSE SDF allocation: inpatients + maternity
- 22/23 £383k from NHSE for Community SMI
- 23/24 TBC – awaiting confirmation from NHSE

(>90% costs are workforce costs)

Leadership and governance arrangements:

- Trust level Smokefree committees and Smoking In Pregnancy meetings.
- NEL Tobacco Dependence Treatment Programme steering group.
- NEL Population Health & Health Inequalities steering group.
- NEL Respiratory Clinical Network.

Key delivery risks currently being mitigated:

- Ensuring sustainability post the initial three-year programme mobilisation period.
- Yearly funding cycles by NHSE (and very late confirmation of funding).

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce		Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

NEL Homelessness Programme / Place Based Partnerships / Ellie Hobart, Deputy Director of Strategy, NHS NEL, ellie.Hobart@nhs.net

The benefits that North East London residents will experience by April 2026

Those that experience homelessness will ….

- **have better health and social outcomes – through improved access to primary care and community services including mental health and drug and alcohol services,**
- **no longer be discharged to the streets and access step down accommodation that supports onward support out of homelessness**
- **be supported to improve their health and to be able to take increasing responsibility for their own health and wellbeing**
- **have better transitions between settings with pathways that are joined up and focus on the individual and provide wrap around care and support**
- **have better pathways for young people at risk of becoming homeless due to poor health and/or adverse circumstances by identifying those at risk earlier and providing wrap around support and timely interventions**
- **have safer environments that promote physical and psychological wellbeing**
- **have more opportunities for getting involved in the design and delivery of services.**

How this transformation programme reduces inequalities between north east London's residents and communities:

- People experiencing homeless have significantly worse health outcomes & poorest access to services they face extremely elevated disease risks and mortality risks which are eight to twelve times higher than the general population. Average age of death is 30 years lower than the national average.
- We also know those that experience homeless are at higher risk of mortality from suicide compared to the general population and report a mental health difficulty.
- Prevalence of dental issues, chest pain, breathing problems, eye problems, skin and wound conditions are higher than the general public and they are more likely to experience asthma, TB, heart disease and Hep C compared to the general population. The homeless are more exposed to extreme weather events and by providing a better housing offer when discharged we can improve recovery rates and management of long term conditions.
- They also suffer from stigma and discrimination which limits access to the services they need. And there is a lack of awareness of healthcare system and entitlements

The NEL programme, which is in line with NICE guidelines, and will contribute to addressing this inequity by through improved access to primary care and community services including mental health and drug and alcohol services, ensuring people are not discharged to the streets, working in partnership with housing and social care to improve awareness of entitlements, and ensuring services are trauma informed and co-designed with those with lived experience.

Key programme features and milestones:

- Sustainable roll out of out of hospital care model April 24
- Consistent coding of homeless in PC and acute April 24
- Homeless dashboard in place Dec 23
- Development of homeless outcome framework April 24
- Outer borough preferred approach to PC access scoped Dec 23
- Consistent homeless health outreach model in place for NEL April 24
- Workforce: – increased access to trauma informed training Dec 23
- OOHCM community practice established July 23
- Live experience approach scoped and mobilised Dec 23

Further transformation to be planned in this area:

- Over the next two years
  - OOHCM expanded to B&D
  - Consistent provision of outreach
  - Primary care access improved in outer boroughs
  - Specialist health visitor provision in temp accommodation
- Over years three to five
  - Prevention programme for young homeless
  - Employment and housing opportunities through anchor programmes
  - Joint pathways for co-occurring conditions

Programme funding:

- TBC – NEL funding being sought through business case process
- Place based funding sits within place

Leadership and governance arrangements:

- Place Based Partnerships – homeless programmes
- NEL Population Health & Integration Committee
- NEL Population Health & Health Inequalities Steering Group (NEL Equity in Health Workstream)

Key delivery risks currently being mitigated:

- Financial risk – OOHCM funded through DHSC - lack recurrent investment combined with high inflation affecting sustainability of current provision – business case being drafted
- Workforce – recruitment and retention of specialist staff, highly stressful roles. Development of community of practice and access to training e.g. compassion circles / trauma informed care
- Stakeholder – set of complex relationships across NEL multiple stakeholders and potential fault lines as housing supply limited. Maintain relationships and ensure inc. as a priority area for addressing HI
- Housing supply limited and expensive – LA unable to provide adequate housing, greater partnership working to mitigate.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	x	Health inequalities	X	Personalised care	X	High-trust environment	X
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Anchors Programme / NEL and Place Based Partnerships / SRO TBC

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Increasing the number of health and care organisations that pay a London Living Wage
  - Increased support to local residents to access careers in health and care sector – workshops, events, clearer routes from training & education
- April 2026:
  - Significant reduction in health and care carbon footprint – therefore improving population health (see details of the net zero programme)
  - Better access to healthcare in a community setting
  - More local suppliers winning health and care contracts.
  - More local residents working in the health and care sector in NEL

How this transformation programme reduces inequalities between north east London's residents and communities:

- Widening access to employment opportunities, training and a providing routes into employment via work experience
- Embedding procurement for social value in our systems contracting and procurement processes
- Maximising the value of our buildings and land
- Supporting a greener and healthier future.

Key programme features and milestones:

- Convene, connect and collaborate how the ICS is delivering on the four workstreams
- Develop a collection of case studies to share anchor work
- Delivery of HEE funded projects in Q1 – Q2 2023/4
- Hosting the Primary Care Anchor Network (PCAN) Manager – first year of a new role funded by HEE
- Support the next steps from the system Cost of Living workshop and ensure learning is shared across relevant groups and programmes
- Agree ambitions for using our land & buildings to benefit local communities.

Further transformation to be planned in this area:

Over the next two years

- Raise visibility of the NEL anchor charter
- Collaborate with colleagues across London to develop an anchors monitoring and evaluation framework
- Sharing and learning from across London and nationally
- Scoping options for poverty proofing practice in NEL with the HI steering group.

Programme funding:

- Health Education England - £250,000. Allocated to workforce development and training programmes that contribute to aims of the anchor workstreams. Non-reoccurring.

Leadership and governance arrangements:

- NEL Anchor Steering Group
- NEL Population Health and Health Inequalities Steering Group.

Key delivery risks currently being mitigated:

- Strengthening programme at Place with NEL team
- Establishing a monitoring and evaluation framework in place for all of the anchor workstreams, without which we risk not effectively making progress against the NEL Anchor Charter.
- Securing a NEL lead for the Anchors procurement workstream. Without this we cannot track progress and implementation of how providers are meeting the 10% minimum on social value in procurement exercises.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health	x	Health inequalities	x	Personalised care		High-trust environment	x
Long-term conditions		Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

Net Zero (ICS Green Plan) / NEL/ Steve Collins, Director of Finance, NHS NEL, steve.collins5@nhs.net

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Access and encouragement to move to prescribed low-carbon inhalers
  - Cleaner air as a result of less staff commuting by car and switch to low emission fleet
  - Greater awareness of the green plan and net zero approach that healthcare organisations are making to reduce their impact on the environment
- April 2026:
  - Reduction in medicine waste
  - Better regulated heating within healthcare buildings and estates
  - Reduction and phasing out of single use plastics
  - Re investment of resources saved by reducing energy and medicines waste

How this transformation programme reduces inequalities between north east London's residents and communities:

- By taking climate action for our population we reduce the severity of climate change and increase the life chances of our population
- By taking climate action for our population we reduce the likelihood of developing as well as exacerbating long term conditions such as asthma
- By taking climate action for our population we will improve access to nutritious food and green spaces therefore improving health and wellbeing.

Key programme features and milestones:

Carbon Footprint - the emissions we control directly

- A 40% reduction by 2025
- An 80% reduction in the emissions we control directly by 2028-2032
- Net zero by 2040.

Carbon Footprint Plus - the emissions we control indirectly

- An 80% reduction in the entire emissions profile by 2036-2039
- Net zero by 2045.

Programme funding:

- Ad-hoc small pots from NHS England
- Seeking GLA funding for green spaces projects
- Breakdown across capital, workforce / care services, programme delivery

Further transformation to be planned in this area:

Over the next year

- Completely removing the use of volatile anaesthetic gases (11% reduction)
- switching all the combined electricity, gas and oil to renewable sources (41% reduction)
- Switching all MDI Inhalers (18% reduction)
- By switching NHS Fleet to electric vehicle and cycles (4% reduction)

Over years two to three

- We will improve the carbon literacy of hundreds of staff
- We will increase capacity in the system by improving the resilience and professional development of the staff delivering Trust and ICS Green Plans
- Review three year plan and create next net zero strategy.

Leadership and governance arrangements:

- NEL Anchor Steering Group
- NEL ICS Green Plan Strategy Group (meet bi-monthly)
- NEL Sustainability Working Group
- Various thematic sub-groups

Key delivery risks currently being mitigated:

- Identifying carbon footprinting experts to monitor how we will become net zero by 2040. If the programme is not able to monitor it's carbon footprint the Green Plan cannot monitor its progress or identify areas of concern.
- Need to identify resources to undertake adaptation planning and expertise. .
- Gap in resource to manage air quality programme – business case in development
- Economic risks due to a long term lack of capital investment, combined with current high levels of inflation affecting material prices for driving change.

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	x	Personalised care	x	High-trust environment	x
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

NEL Refugees & Asylum Seeker Working Group / Place Based Partnerships / Ellie Hobart, Deputy Director of Strategy, NHS NEL, ellie.Hobart@nhs.net

The benefits that North East London residents will experience by April 2026

Those that experience refugee & asylum seeker (RAS) accommodation will have….

- better health and social outcomes – through improved access to initial health assessments, GP registration and care planning that will support access to primary care and community services to meet their needs
- improved access to social prescribing that aligns with primary care pathways - sign-posting people to local CVSF and providing opportunities to integrate into local communities and activities and supporting mental health
- smoother transitions with a health record that follows them and takes a trauma informed approach.
- coordinated and proactive safeguarding

How this transformation programme reduces inequalities between north east London's residents and communities:

- For **asylum seekers and refugees**, their health needs vary significantly but asylum seekers in Initial Accommodation Centres (IACs) and newly arrived refugees face inequalities in accessing health and care services. The programme aims to support access to funding that will lead to increased support to register with a GP and how to access and use the UK health system.
- The RAS cohort will likely face inequalities due to their limited resources concurrent to this they are also likely to require, language, material and social support. The programme is bringing together local authority and health care stakeholders that will be able to support joined up partnership approaches e.g. a highlighted inequalities challenge has been funding for travel expenses to health and care appointments.
- Another inequality being faced relates to not being 'visible' to the health and social care system in the first instance - It is difficult to track the hotels, dispersed accommodation and temporary accommodation in each local authority that is being used to house homeless households **and asylum seekers and refugees** and to therefore have an accurate picture of the homeless population at any given point in time and therefore support them with services. Improving shared data with the home office and housing provider alongside the correct and timely notification of health and social care providers will benefit those 'unseen' individuals.
- VCS organisations supporting the RAS cohort highlighted the inequality faced due to a poor understanding of how to access and navigate the system and fear of doing so. Inequalities due to this may be reduced via developing agreed and consistent information/ communication across the NEL partners e.g. contact points such as accommodation and GP practices

Key programme features and milestones:

- Establishment of NEL RAS working group in Sept 2022 – in response to place based partnerships seeking support for more co-ordination at a NEL footprint to the challenges of an increasing number of contingency hotels being set up in NEL.
- Improving key networks and establishing stakeholder relationships across place based partnerships and regional / national bodies e.g. GLA, UKHSA etc
- Scoping of 4 key 'priority' areas of NEL focus (primary care access/ safeguarding, data & data sharing, health protection)
- Development of generic NEL wide outreach specification for PC and implementation July 23
- Creating space to share learning across NEL

Programme funding:

- TBC – Potential NEL funding to be sought via business case related to Health Inequalities
- Place based funding potential sits within place

Further transformation to be planned in this area:

- Over the next two years
  - Coproduce outcomes for RAS population that align to our four work programme areas with system Place stakeholders
  - Support the place based partnerships in delivering against the four priority areas,
  - Forge improved relationship with home office and accommodation providers in order to improve health and care of cohort
  - Align to anchors charter and develop opportunities for employment in health services for RAS population
- Over years three to five
  - Enable improved access to dental, pharmacy and ophthalmology for this cohort
  - Implementation of national/ regional clinical templates for consistent capture and coding of asylum seeker status and assessments
  - Strategic approach to consistent best practice in the provision of welfare and wrap around support by local authorities for home office accommodation residents

Leadership and governance arrangements:

- Place Based Partnerships – local leads both LA and NHS
- NEL Population Health & Integration Committee
- NEL Population Health & Health Inequalities Steering Group (NEL Equity in Health Workstream)

Key delivery risks currently being mitigated:

- The unknown timelines, location and quantity of hotels being stood up by the home office at short notice is the largest risk. Linked to this are the unknown numbers of individuals expected to be accommodated at each site.
- Financial risk –lack recurrent investment combined with high inflation affecting sustainability of current provision i.e. £150 per person getting registered with a GP with no government funds to support initial health outreach services.
- Workforce – recruitment and retention of specialist staff, highly stressful roles.
- Stakeholder – set of complex relationships across NEL and lines of responsibility and accountability due to multiple stakeholders including Clearsprings Ready Home and the Home Office.

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health	x	Health inequalities	X	Personalised care		High-trust environment	X
Long-term conditions	x	Employment and workforce	x	Prevention	x	Co-production	x	Learning system	x

Transformation in NEL

North East London Health & Care Partnership

NEL Discharge Pathways Programme / Nina Griffith, Workstream Director, NHS NEL nina.griffith@nhs.net

Overview: Across north east London, all places are working to improve discharge. The aim is to ensure faster discharges and that people are being moved into the correct place to support their needs. Although discharge is place based, there are some common approaches across the ICB, this includes:

- Encouraging a home first approach
- Continued improvement of the transfer of care hubs
- Promoting independence and reablement

City and Hackney: Hackney council has commissioned PPL to conduct an evaluation of the discharge infrastructure and pathways for the Homerton hospital. The diagnostic phase and future planning process has started and will conclude at the end of March 2023. The output will be a shared understanding of successes and challenges across the local system with focus on areas of opportunity. This process will develop a vision for change with a project plan with clear performance targets and a framework to measure performance.

Tower Hamlets: Development of a single streamlined discharge model moving away from the current 3 team model.

Newham: Appointing a single Head of Discharge for Newham, managing the joint team.

Waltham Forest: Implementing the Home First Business Case including developing integrated rehab and reablement provision.

TNW: Delivery of the Newton recommendations ensuring we have Advance Care Planning, Imbedding Discharge to Assess, reduction in use of step down provision, improved use of Intermediate Care and using digital tools to ease discharge process.

Barking and Dagenham, Havering and Redbridge: BHR have reviewed reasons for discharge delay and have set up 3 task and finish groups focusing on discharge to assess home, review of the integrated discharge hub and review of rehab pathways.

The benefits that north east London's residents will experience by April 2024 and April 2026:

- April 2024:
  - Reduction in delayed discharges
  - Increased number of people being discharged home
  - Reduction in readmissions due to poor discharge planning
  - Reduction in use of step down provision
  - Reduction in delayed discharges in hospitals of Out of Area (outside borough) residents.
- April 2026:
  - Continued improved against the benefits seen by April 2024
  - Increased number of people accessing reablement and living independently post-discharge

Programme funding:

- Overall sum and source: in 2023/24, NEL ICB will receive £12m from a pot of £600m as part of UEC recovery plan

How this transformation programme reduces inequalities between north east London's residents and communities:

- This programme works to identify areas of improvement across the different places by sharing of learning, for example, we are working to understand what is being funded in each place for each D2A pathway and IDH. Furthermore, we are continually working to improve performance against the BCF metrics related to discharge.

Key programme features and milestones:

- Focus on reducing delayed discharges
- Focus on reablement and supporting people to live independently
- Focus on home first approach

Key delivery risks currently being mitigated:

- Financial risks, particularly if funding is reduced
- Workforce risks particularly in the care sector, there are workforce improvement and recruitment projects in each place

Further transformation to be planned in this area:

- Over the next two years
  - Focus on transfer of care hubs
  - Focus on delayed discharges
  - Focus on improving discharge processes
- Over years three to five
  - Focus on reablement and supporting people to live independently post-discharge
  - Focus on shifting the culture on discharge

Leadership and governance arrangements:

The discharge programme is primarily delivered within the places. Within each place, there is a mobilised programme that is led by one or more of the following:

- Local authority leadership via DAS
- Hospital leadership via COO or equivalent
- ICB leadership via Head of Age Well or Place Director

Oversight is maintained at NEL level via the NEL discharge group and regular assurance is provided to NHSE.

Alignment to the integrated care strategy:

Babies, children, and young people		Mental health		Health inequalities		Personalised care		High-trust environment	
Long-term conditions		Employment and workforce		Prevention		Co-production		Learning system	

Transformation in NEL

North East London Health & Care Partnership

Pharmacy and Medicine Optimisation/ NEL / SRO:Dr Raliat Onatade, ICS Chief Pharmacist and Director of Medicines and Pharmacy NHS NEL- raliat.onatade@nhs.net

The benefits that North East London's residents will experience by April 2024 and April 2026:

April 2024:
- All eligible residents particularly those in areas of social deprivation and/or on low income will have equitable access to medications for minor ailments for self-care without needing a prescription.
- Patients will be supported to self-manage certain minor illnesses without the need of seeing a GP
- Better management of their health especially with self-care of minor conditions by community pharmacies is an opportunity to solve GP appointment crisis and drastically improve patients' access to general practice
- Reduce the number of GP appointments and/or A&E attendance for conditions related to specific minor illnesses and ailments
- Freeing up GP appointments will lead to reduced work load on local GPs and increased access for complex patients being seen in a timely manner and hopefully decreased NHS waiting times.

April 2026:
- All residents with a minor ailment will have rapid access to medicines for self-care and advice to empower them to manage their own condition effectively and avoid repeated GP or A&E attendances
- Improve access to prepayment certificates for patients with a long-term condition and those requiring occasional medications
- Personalised care - population Health and primary care Management to support cohort identification and quality care interventions delivered through implementation of NEL LTC outcomes framework

How this transformation programme reduces inequalities between north east London's residents and communities:
- Through the reduction of additional inequality in health outcomes between residents who are financially challenged. Residents in more deprived areas were less likely to collect their medication for self-care due to the cost of the medications
- By reducing unwarranted variation in access to over the counter (OTC) items free from the pharmacy for self-care of minor ailments (currently only residents across C&H were receiving this within NEL)
- The impact of increased appointments for prescriptions of OTC medicines for minor ailments (by patients who cannot afford to buy OTC medicines for self-care) on local GPs would result in some complex patients being unable to access urgent GP appointments or seen in a timely manner

Key programme features and milestones:

- Business case developed for NEL ICB – April 2023 –
- Ensure equitable access for identified cohorts of eligible patients to obtain over the counter (OTC) items free from the pharmacy for self-care including homeless, refugees, asylum seekers (Q1 23/24)
- Establish robust primary care engagement with all key stakeholders including LMC and LPC to improve patient outcomes and experience (Q1 23/23)
- Evaluation and targeting uptake in identified underserved populations (Q1 23/23)

Further transformation to be planned in this area:

Over the next three years
- To provide access to prepayment certificates for patients with a long-term condition and those requiring occasional medications. (TBC 2023)
- We recognize this scheme may be unaffordable in this financial year but will be considered in the next year.

Programme funding:
- None. Likely Health Inequalities (NEL wide shared ambition) or cross borough with place based partnerships programmes of work.
- An annual recurrent funding of £1,569,645.93 is required.

Leadership and governance arrangements:
- Clinical leads (pharmacy and Medicine optimisation and primary care)
- Working groups – Quality, Insight, Finance. Comms, Contract , PMO leads
- Cross working across place Based Partnerships

Key delivery risks currently being mitigated:
- Funding- concerns around recurrent- funding required for the scheme
- ICB workforce sustainability – uncertainty around FTC roles due to the consultation – not mitigated

Alignment to the integrated care strategy:

Babies, children, and young people	x	Mental health		Health inequalities	x	Personalised care	x	High-trust environment	
Long-term conditions		Employment and workforce		Prevention	x	Co-production		Learning system	