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Health and Social Care Scrutiny Committee

Date: **WEDNESDAY, 15 MAY 2024**

Time: **11.00 am**

Venue: **COMMITTEE ROOM 1 - 2ND FLOOR WEST WING, GUILDHALL**

Members:
Deputy Christopher Boden
David Sales
Michael Hudson
Andrew Mayer
Deborah Oliver
Deputy Alpa Raja
Steve Stevenson

Enquiries: **Jayne Moore**
Jayne.moore@cityoflondon.gov.uk

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Ian Thomas CBE
Town Clerk and Chief Executive

AGENDA

Part 1 - Public Reports

1. **APOLOGIES**

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

3. **ORDER OF THE COURT OF COMMON COUNCIL**
To receive the order of the Court of Common Council of April 2024.
For Information
(Pages 5 - 6)

4. **ELECTION OF CHAIR**
To elect a Chair in line with Standing Order No.29.
For Decision

5. **ELECTION OF DEPUTY CHAIR**
To elect a Deputy Chair in line with Standing Order No.30
For Decision

6. **MINUTES**
To agree the public minutes of the meeting of 24 January 2024.
For Decision
(Pages 7 - 12)

7. **FORWARD PLAN**
To note the forward plan.
For Information
(Pages 13 - 14)

8. **ADULT SOCIAL CARE SELF-ASSESSMENT**
To receive the report of the Executive Director, Community and Children's Services.
For Information
(Pages 15 - 48)

9. **DRAFT NEL FORWARD PLAN**
To receive the report of the Director of Partnerships, Impact and Delivery, NHS North East London Integrated Care Board & City and Hackney Place Based Partnership, part of North East London Health and Care Partnership.
For Information
(Pages 49 - 112)

10. **PATIENT CHOICE IN SECONDARY CARE**
To receive the report of the Deputy Director Contracting, NHS North East London, Part of North East London Health and Care Partnership.

For Information
(Pages 113 - 118)

11. **PATIENT CHOICE IN PRIMARY CARE**
To view the presentation of NHS North East London, Part of North East London Health and Care Partnership.

For Information

12. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

13. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

14. **EXCLUSION OF THE PUBLIC**
MOTION - That under Section 100(A) of the Local Government Act 1972, the public be excluded from the meeting for the following items on the grounds that they involve the likely disclosure of exempt information as defined in Part I of the Schedule 12A of the Local Government Act.

Part 2 - Non-Public Reports

15. **NON-PUBLIC MINUTES**
To agree the non-public minutes of the meeting held on 17 January 2024.

For Decision
(Pages 119 - 120)

16. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

17. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

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MAINELLI, Mayor	**RESOLVED:** That the Court of Common Council holden in the Guildhall of the City of London on Thursday 25th April 2024, doth hereby appoint the following Committee until the first meeting of the Court in April, 2025

HEALTH & SOCIAL CARE SCRUTINY COMMITTEE

1. **Constitution**
A non-Ward Committee consisting of,
- Any 6 Members appointed by the Court of Common Council
- 1 Co-opted Healthwatch representative.

The above shall not be Members of the Community & Children's Services Committee or the Health & Wellbeing Board.

2. **Quorum**
The quorum consists of any three Members. [N.B. - the co-opted Member does not count towards the quorum]

3. **Membership 2024/25**

5	(4)	Andrew Paul Mayer
3	(3)	David James Sales *for three years*
2	(2)	Alpa Raja, Deputy *for two years*
3	(3)	Christopher Paul Boden, Deputy
3	(2)	Michael Hudson
2	(2)	Deborah Oliver TD

Together with the co-opted Member referred to in paragraph 1 above.

4. **Terms of Reference**
To be responsible for:-

(a) fulfilling the City's health and social care scrutiny role in keeping with the aims expounded in the Health and Social Care Act 2001 and Part 14 of the Local Government and Public Health Act 2007 (Patient and Public Involvement in Care and Social Care) and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013;

(b) agreeing and implementing an annual work programme; and

(c) receiving and taking account of the views of relevant stakeholders and service providers by inviting representations to be made at appropriate meetings.

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HEALTH AND SOCIAL CARE SCRUTINY COMMITTEE
Wednesday, 17 January 2024

Minutes of the meeting of the Health and Social Care Scrutiny Committee held at Committee Room 2 - 2nd Floor West Wing, Guildhall on Wednesday, 17 January 2024 at 11.00 am

Present

Members:
Deputy Christopher Boden (Chairman)
David Sales (Deputy Chairman)
Michael Hudson
Andrew Mayer
Deborah Oliver
Deputy Alpa Raja

Officers:

Simon Cribbens	-	Community and Children's Services
Ellie Ward	-	Community and Children's Services
Jayne Moore	-	Town Clerk's Department
Chris Pelham	-	Community and Children's Services
Rachel Talmage	-	Community and Children's Services
Hannah Dobbin	-	Community and Children's Services
Anna Hanbury	-	NHS Northeast London
Jane Naismith	-	St John's Hospice
Matthew Hopkinson	-	NHS Northeast London
Amaia Portelli	-	NHS Northeast London
Robert Nsiiro	-	The Neaman Practice

1. **APOLOGIES**
There were no apologies.

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
Deborah Oliver declared these two interests:
Agenda Item 4: patient of the Neaman Practice; and
Agenda Item 7: Governor of Royal Bridewell Hospital (King Edward and Barrow hills Schools).

No other declarations were made.

3. **MINUTES**
RESOLVED – That the minutes of the meeting of 04 October 2023 be agreed as a correct record.

4. **NEAMAN PRACTICE UPDATE**

The Committee viewed a presentation updating Members on the Neaman Practice following its improvement plan, noting in particular the following:

- The overseeing by the Regional Digital First teams (NEL) of a distinct process aimed at identifying practices on analogue telephony systems, with funding allocated to facilitate: i) the buyout of existing contracts if necessary, ii) the procurement of digital/cloud-based telephony licenses, and iii) local implementation support;
- The introduction of tools to facilitate the transition to Modern General Practice (MGP);
- Staff training and local improvement support;
- Means of communication with patients;
- The consideration of a plan for offering an outcome to patients at first point of contact with a practice via
- Options for patients to have needs assets via an online consultation through the practice website or using e-Consult,
- Re-structured appointment system,
- Fulfilment of contractual obligation by achieving prospective record access for patients, which became active on October 25, 2023 allowing all patients with consent, who have signed up for online access, to remotely review their records,
- Recognition of significance of participating in the PCN Improvement Leads programme, and
- Working with the national Digital & Transformation Leads development programme team to receive extended support over a twelve-month period to include action learning set sessions, individual Quality Improvement (QI) coaching sessions, and guidance towards signposting to other learning opportunities such as webinars.

Members asked for more information on performance, measuring and KPIs, and on how issues and concerns were gathered. The meeting heard that patient feedback was gathered via Patient Participation Groups and feedback forms and that some issues related to patient triage and how patients were signposted to the right support, and that day-to-day capacity was monitored. Members heard that data was benchmarked against other local practices.

A Member asked whether any GPs had special interests – the meeting heard that a GP partner specialised in dermatology and ran a skin clinic once a week that is bookable through Reception or by referral.

Members asked what was being offered to carers and whether carers were given any priority. The meeting heard that all carers were noted and monitored and that carers were always prioritised and that primary carer health was the subject of a neighbouring pilot scheme that was being examined for implementation.

A Member asked how effective were the social prescribers. The meeting heard that these sessions were held once a week and patients were usually referred to attend 30-minute social prescriber sessions (three for the practice as the

social prescriber was shared among 5 practices). Members commented that three sessions for the practice appeared limited.

A Member asked what three benefits would be noticed following the plan: the meeting heard that the practice was recognised and appreciated for its diverse and welcoming team, the efficiency of the clinical team, and the good relationship with patients as evidenced by feedback.

A Member asked for further clarification on the practice's interaction with the 111 service, and whether there appeared to be patients using the 111 service if they were unable to access GP services. The meeting noted that the practice was integrated into the 111 system, and that patients were not signposted by the practice to the 111 service.

A Member sought reassurance that the practice put patients at the heart of decision-making at the practice.

The meeting noted that performance data would be provided in advance of attendance at a future meeting.

5. **UPDATE ON VIRTUAL WARDS**

The Committee viewed a presentation delivered by the Programme Lead – Unplanned Care, City and Hackney NHS North East London setting out updates on virtual wards, noting in particular the following:

- NHS national priorities and operational planning guidance;
- delivery of virtual wards now sits with Place teams, with the NEL Urgent and Emergency Care Programme providing overall system oversight;
- finance allocations for 2023/24;
- virtual ward referral pathways;
- impacts and benefits of virtual wards; and
- next steps.

On sharing best practice and learning, a Member asked for further information on sharing digital tools. The meeting heard that best practices were shared across NEL and that a range of practice communities shared best practice including digital technology tools.

On funding from NHS England, a Member commented that while in theory funding could be diverted from hospital bed use, expansion was such that escalation beds were being used and that hospital wards were not necessarily being shut. Consideration was being given on how more could be done within the community through virtual wards, and that provided appropriate technology was being used virtual wards would be more affordable per bed in the longer term.

On the three categories of patients, a Member commented that most patients would have multiple conditions and asked how these were prioritised and whether co-morbidities might preclude the virtual ward setting. The meeting heard that patients who benefited the most from virtual wards tended to have

complex conditions, and would be handled by a lead consultant in the same way as would such a patient in a hospital environment. The meeting also heard that all cases were assessed for suitability to virtual wards.

A Member asked why virtual ward provision had taken so long to roll out given that the technological tools have been available for nearly two decades. The meeting heard that virtual ward provision has been taking place for some time, and has accelerated since covid with patients becoming more comfortable with the experience over time.

A Member asked how early adopters were finding the virtual ward experience and whether there was any data on patient outcomes. The meeting heard that outcome effectiveness was difficult to measure – noting Member comments that virtual ward provision could not be measured solely in terms of cost effectiveness and must result in better patient care overall.

A Member commented that given the compactness of the City of London it was noted that nurses would not have to travel far to manage virtual wards.

6. **UPDATE ON CURRENT END-OF-LIFE SUPPORT AND IMPACT**

The Committee viewed a presentation delivered by the Programme Manager at Start Well and Age Well at City & Hackney Place-Based partnership, the joint CEO and Director of Clinical Services at St Joseph's Hospice, and the Joint Director of Operations and City & Hackney GP Confederation. The presentation set out updates on current end-of-life support and impact and the Committee noted in particular the following:

- An overview of community and inpatient Palliative and End of Life Care (PEoLC) services in the City of London;
- A summary of the NHS North East London ICB Palliative and End of Life Care Strategy;
- Activity and progress on End of Life Care within Primary Care in City & Hackney (with detail from the Neaman Practice);
- Overview of the Marie Curie Overnight End of Life Care Rapid Response Service; and
- Report from St Joseph's Hospice covering key activity, inpatient ward re-development, work to improve links with community services, and achievements.

The Committee noted the PEoLC strategy at the NHS North East London; the 2024/25 priority on embedding activities that focus on practices' EoL procedures at micro practice level; the Marie Curie Rapid Response Service; and the activities of St Joseph's Hospice.

A Member congratulated the Hospice for its warmth and friendliness noted during a visit in 2023.

A Member asked for more information on the triage process for patients ending their lives in hospices. Members heard that patients tended to express a preference, and that referrals tended to come from palliative care teams. The

meeting noted that many patients would be admitted a few times for symptom management.

A Member sought further information on hospice capacity and how that related to funding sources. The meeting heard that funding came from a range of sources including grants, and that fundraising was a real challenge particularly in respect of expanding the community team and that virtual wards for palliative care were worthy of future consideration.

A Member asked how the quality of death was judged, noting the obvious challenge in obtaining personal feedback. The meeting noted that bereaved relatives were surveyed, and that 90% of relatives had felt that patients had died in the right place (following a survey a few years ago). The meeting noted that preferred place of death was not necessarily a metric of a 'good' death and was, rather, a proxy measure given that end-of-life situations could change rapidly. Members noted the role of unwanted medical interventions, and the potential for better education around the end-of-life process.

7. **CHILDREN'S SOCIAL CARE SELF EVALUATION FRAMEWORK**

The Committee received the report of the Executive Director, Community and Children's Services on the Children's Social Care Self-Evaluation Framework.

Members noted that the non-public paper carried an exemption, noting that names had already been redacted (noting also that identification was also possible in theory). Members commented that future such items should be presented as Public items – at least wholly or in part, with appropriate redactions where necessary.
Members noted that the paper was positive for the City of London Corporation, reflecting the Corporation's policy decisions to boost children's services and to continual improvement.

The meeting was extended beyond 1pm with the agreement of all Members.

8. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

The Committee noted that in May, at least these three topics would be covered:
-Self-evaluation of adult social care services
-Evaluation of special educational needs and disability services for children and young people
-Update on low-paid workers/access to healthcare;

and that these topics would be covered in later meetings:
-Patient choice and access to health services (the right to have treatment at the place of choice, including for City workers)
-Clarification of postcode provision to ambulance service following a recent incident at Guildhall in which an ambulance was apparently unable to assist an unwell person due to confusion over the correct postcode, the meeting heard that the matter would be investigated. The meeting noted that the issue had been raised and that a response was awaited and that further information would be circulated to Members within a week.

A Member asked for briefings to presenting officers to highlight discussions of impact and performance.

9. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
There was no other business.

10. **EXCLUSION OF THE PUBLIC**
RESOLVED, that – under Section 100(A) of the Local Government Act 1972, the public be excluded from the meeting for the following items on the grounds that they involve the likely disclosure of exempt information as defined in Part I of the Schedule 12A of the Local Government Act.

The meeting ended at 1.23 pm

Chairman

Contact Officer: Jayne Moore

Health and Social Care Scrutiny Committee forward plan 2024

Topic	Speaker	Suggested meeting
Immunisations	Public Health	Summer 2024
Special Educational Needs and Disabilities (SEND) Self-evaluation (SEF)	City of London Corporation	Summer 2024
Estates Strategy	City of London Corporation	Summer 2024
Neighbourhood evaluations	Neighbourhoods team	Summer 2024
Update on low-paid workers/access to healthcare	Public Health	Summer or Autumn 2024
Neaman Practice KPIs and performance data update	Neaman Practice	Autumn 2024
Foot health		
Never events		
System priorities for health and social care		
Community Drugs Partnership		
Health Support for Unaccompanied Asylum-Seeking Children		
Direct Payments		
Dementia Services		
Health and Wellbeing Network		

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Committees: Community & Children's Services Committee – For Information Health & Social Care Scrutiny Committee – For Information Safeguarding Sub-Committee – For Information	**Dated:** 01/05/24 15/05/24 16/04/24
Subject: Adult Social Care Self-Assessment	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	1, 2, 3, 4
Does this proposal require extra revenue and/or capital spending?	**N**
If so, how much?	**N/A**
What is the source of Funding?	**N/A**
Has this Funding Source been agreed with the Chamberlain's Department?	**N/A**
Report of: Judith Finlay, Executive Director, Community and Children's Services	**For Information**
Report author: Scott Myers, Strategy & Projects Officer	

Summary

This report introduces the City of London Corporation's Adult Social Care Self-Assessment 2024, which will support the inspection of our Adult Social Care services by the Care Quality Commission (CQC).

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. The Health and Care Act 2022 introduced a new inspection regime for local authority Adult Social Care services, to be carried out by the CQC. Traditionally, only services that provide direct care – for example, reablement services, homecare and residential care – have been subject to inspection in the Adult Social Care field.

2. The roll-out of the inspection regime has started following a pilot period with several local authorities.

3. As with other inspections, we are required to produce a self-assessment to support the inspection of our services. Although there is no set format or

template for the Self-Assessment Framework (SEF), it is designed to provide a space for the local authority to reflect on their delivery and performance, their challenges and how they have responded to them, and the impact they have had on Adult Social Care clients.

Current Position

4. As part of our inspection preparation which this self-assessment supports, the City Corporation has a specific programme in Adult Social Care focusing on transformation and inspection. The programme board is chaired by the Executive Director of Community and Children's Services.

5. In August 2023, in co-operation with the Local Government Association, our inspection readiness was tested by a peer review and areas that are likely to be raised within an inspection. This peer review complemented our self-assessment and did not raise any areas of concern.

6. An Adult Social Care Service Improvement Plan will be established to support the improvement work emerging from the SEF. This improvement plan will include an update on service outcomes and will be submitted to Members on a six-monthly basis.

Key themes from the Adult Social Care Self-Assessment

Vision

7. Our vision is for residents to get the right information, advice, support and care to live their best lives, maintain their health and wellbeing, and live safely in the place of their choice.

Strengths-Based Approach

8. One of our key strengths is our personalised and strengths-based approach to identify and deliver individual outcomes, and there is strong partnership working to deliver this. Though there are specific challenges around complex needs (specifically rough sleepers), there has been a proactive and innovative response which has reduced risk in this area.

Commissioned Placements

9. Some of our key areas of work include: strengthening triangulation around commissioned placements; developing a stronger performance culture within the service; strengthening quality assurance; and improving on some specific processes such as timeliness of reviews.

10. There are no accommodation-based support options within our boundaries, and placements are therefore purchased when required (also known as spot purchasing). A project is underway to make this process more efficient, to strengthen quality assurance and to triangulate this with our practice and systems.

Adult Social Care Workforce

11. The City of London Adult Social Care workforce is stable and experienced, creating a flexible and agile response to need. A strengths-based approach practice model and manageable workloads allow staff the time to build relationships and trust with people to identify and meet their outcomes. Strong partnership working across the system supports this approach.

Hospital Discharge

12. We have developed a new hospital discharge model and an innovative social worker post within the Homelessness Team.

Carers

13. Our specific support to carers has been strengthened and our new carers strategy will continue to focus on supporting carers.

Co-production

14. Our aim is to co-produce the Adult Social Care services that are needed. Going forward, our engagement with service users and their feedback will be strengthened to provide us with richer data on how outcomes are achieved and the impact this has. Essential information and how it is provided to services users is currently being reviewed.

Safeguarding Practice

15. Safeguarding practice in the City of London is robust, and the promotion of safety and reduction of risk is built into both our internal and external systems. Our Safeguarding Adults Board function is delivered jointly with the London Borough of Hackney but with an additional sub-group for the City of London to ensure a specific focus.

Areas for Improvement

16. The self-assessment sets out several improvements that focus on strengthening our existing robust work. These are summarised in the 'Key themes' paragraphs 7 to 15 above, and are included in the Adult Social Care Service Development Plan.

Corporate & Strategic Implications

17. There are no strategic implications directly related to this report.

- Strategic implications – None identified.
- Financial implications – None identified
- Resource implications – None identified

- Legal implications – None identified
- Risk implications – None identified
- Equalities implications – None identified
- Climate implications – None identified
- Security implications – None identified

Conclusion

18. The City of London Corporation's Adult Social Care self-assessment shows that our practice and service to residents is good quality, but there are areas of development around systems and processes that could be delivered to strengthen the service further.

Appendices

• Appendix 1 – Adult Social Care Self-Assessment 2024

Scott Myers
Strategy & Projects Officer
Community and Children's Services

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City of London Adult Social Care Self-Assessment
February 2024

Overall Summary and Assessment

The City of London and its governing body, the City of London Corporation are unique. There are 8,600 residents who live in the Square Mile, 14% of whom are aged 65 or over. There is high life expectancy in the City of London and this, coupled with the high number of rough sleepers in the City of London, create the key drivers of demand for health and social care support in the City of London.

Our vision is for residents to get the right information, advice, support and care to live their best lives, maintain their health and wellbeing, and live safely in the place of their choice.

There is one commissioned homecare provider and a high rate of people who have a direct payment to purchase their own provision. There are no accommodation-based support options within our boundaries and placements are therefore spot purchased. A project is underway to make this process more efficient, to strengthen quality assurance and to triangulate this with our practice and systems.

The City of London Adult Social Care workforce is stable, experienced and generic, creating a flexible and agile response to need. A strengths-based approach practice model and manageable workloads allow staff the time to build relationships and trust with people to identify and meet their outcomes. Strong partnership working across the system supports this approach.

Our service is innovative and impactful, operating in a complex, high risk and financially challenging environment. Complex hospital discharge and rough sleeper cases present specific challenges for us but a new hospital discharge model and innovative rough sleeper social worker post within homelessness have helped reduce some risk. These areas remain specific challenges for us, however. Census data shows there are nearly 500 unpaid carers in the City of London. Recently, specific support to unpaid carers has been strengthened and more unpaid carers have been identified. A new Carers Strategy will continue to focus on this.

Innovative approaches to care and support planning in partnership with the individual are put in place and people are supported with direct payments where desired and appropriate. Our aim is to co-produce the ASC services that are needed. Going forward our feedback and engagement with service users will be strengthened to have richer data on how outcomes are achieved and the impact this has. The information provided to services users and how is currently being reviewed.

Safeguarding Practice in the City of London is robust, and the promotion of safety and reduction of risk is built into both our internal and external systems. Our Safeguarding Adults Board function is delivered jointly with the London Borough of Hackney but with an additional sub-group for the City of London to ensure a specific focus.

The City of London Corporation is governed by a committee system and the Adult Social Care Service and budget is governed by the Community and Children's Services Committee. There are also strong links to the Health and Wellbeing Board and services are also scrutinised by the Health and Social Care Scrutiny Committee. There is strong political support for Adult Social Care.

In response to new legislative requirements and knowing our areas for development, an Adult Social Care Transformation Programme is currently being delivered.

Our overall assessment is that our practice and service to residents is good quality but that there are areas of development around systems and processes. One of our key strengths is our personalised and

strengths-based approach to identify and deliver individual outcomes and there is strong partnership working to deliver this. Though there are specific challenges around complex needs, there has been a proactive and innovative response which has reduced risk in this area. Some of our key areas of work include strengthening triangulation around commissioned placements, developing a stronger performance culture within the service, strengthening quality assurance and improving on some specific processes such as timeliness of reviews.

Overview

The City of London

The City of London, also known as the Square Mile, is the financial centre of the UK. It has 8,600 residents, half a million daily commuters and 10mn visitors a year. It sits at the heart of London and is surrounded by 7 local authorities.

The number of residents in the City of London has increased by 16% since 2011. The majority are working age but there are 1200 people - 14% - who are aged 65 and over. Although the percentage of population aged over 65 has stayed the same between the censuses, the actual number of people has increased. There is high life expectancy in the City of London with females having a life expectancy at birth of 90.7 years and males 88.8 years.

Compared with the England average, overall, the City of London has significantly lower levels of income deprivation, child poverty and older people in deprivation. However, according to the Indices of Multiple Deprivation 2019, the City of London's most deprived ward, Portsoken, on the east side of the City of London, was among the top 20% in the country for levels of income deprivation, including income deprivation affecting older people. The Mansell Street & Petticoat Lane area is the most deprived in the City of London falling into the 40% most deprived in England.

Asian people are the largest global majority group in the City of London accounting for 16.8% of the population; and 3% of the City of London population are Black according to the 2021 census. Portsoken, in the east of the City of London is the most ethnically diverse ward.

Census data shows that the City of London has 496 self-identified unpaid carers. The majority provide 19 hours or less of unpaid care per week. However, there are a small percentage who provide upwards of 20 hours per week.

There are a significant number of people sleeping rough in the City of London. In 2022 (the most recent full year data) 372 people were rough sleeping within the boundaries of the City of London which is the 7th highest level amongst London's local authorities. Many of these rough sleepers have significant mental health or substance misuse issues.

There is one GP Practice in the City of London which has around 75% of City of London residents registered while around 16% of residents (on the east side of the City of London) are registered with Tower Hamlets GPs. All these practices now sit within the North East London Integrated Care System. In terms of acute hospitals, City of London residents generally go to the Royal London Hospital in Tower Hamlets or University College Hospital London in Camden (which is in the North Central London Integrated Care System). Community Services for City of London residents are provided by Homerton Hospital. This creates a complex pattern of service delivery for City of London residents.

The City of London Corporation

The City of London Corporation (the City Corporation) is the governing body of the Square Mile and provides local authority services to its residents. The City Corporation has 125 Members operating on a committee system and has its own Lord Mayor and independent police force.

The Department of Community and Children's Services delivers local authority services including social care, homelessness and rough sleeping, public health, education and SEND, housing and libraries.

The Corporate Plan is being relaunched in 2024 and the Community and Children's Services Business Plan will support the outcomes in the Plan. The Departmental Business Plan focuses on safety, independence and choice, potential, health and wellbeing and community.

The Department also delivers several strategies including Homelessness and Rough Sleeping, Carers, and Joint Health and Wellbeing.

Adult Social Care

Key Statistics

181 Residents requesting support from ASC services (2022/23) **94** April – December 2023	**102** Discharges from hospital supported (2022/23) **86** April – December 2023	**96** Adults receiving a Long – Term Service on 31 December 2023	**34** Carers Supported on 31 March 2023 **33** 31 December 2023
24 Safeguarding Enquiries (2022/23) **16** April – December 2023	**50%** Percentage of all working age clients receiving care and support related to Mental Health on 31 December 2023	**42%** Percentage of all clients aged 65+ receiving Personal Care and Support on 31 December 2023	**£6.3mn** Adult Social Care Gross Budget 2023/24

Our vision is for residents to get the right information, advice, support and care to live their best lives, maintain their health and wellbeing, and live safely in the place of their choice.

Our skilled workforce will work with people through the options, and actively champion equality, diversity and inclusion so all people can get the support they need, when they need it.

This underpins all our work and our practice model. The table below sets out some of the key principles of the Care Act 2014 and ASC good practice and how the City Corporation approaches this.

Principle	City of London Corporation Approach
Empowerment, engagement and co-production	A Strengths Based Approach practice model is used in the Service which places the individual at the centre, working with individuals to identify their outcomes and using these to underpin all the actions taken together from there. Individuals or their advocates are involved in care planning and review processes. Innovative approaches to care and support planning in partnership with the individual are put in place and people are supported with direct payments where desired and appropriate (see theme 2). In 2021, the homecare service was recommissioned, and this was a co-produced approach (see theme 2). There is a recognition that we need to strengthen our approach to co-production with service users and we are currently developing this approach. Going forward our feedback and engagement with service users will be strengthened to have richer data on how outcomes are achieved and the impact this has. The information provided to services users and how is currently being reviewed. An Anti-Racist Practice Framework has recently been adopted across Adult Social Care which is being embedded into the service with staff. There is also a range of other initiatives to strengthen our approach to equality and inclusion (see theme 4) and a key area of work for us is to strengthen the collation and recording of equalities data and use this to inform and shape service delivery.
Safety, protection and risk management	Safety, protection and positive risk management are all embedded into our system work (see theme 3). This is in place right from the start, in our preventative work, with our commissioned providers and with our colleagues at the City Corporation. In meeting our statutory requirements around safeguarding, a timely, proportionate and person-centred approach to managing risk is used. There is good feedback from Making Safeguarding Personal in terms of meeting people's outcomes and reducing or removing risk (see Theme 3) ASC are active partners in the local Safeguarding Adults Board (City and Hackney Safeguarding Adults Board) but also have a specific City of London focus through a designated sub-group which is chaired by the Chair of the Safeguarding Adults Board.
Prevention and delay of needs	Prevention is a key tenet of all our work in ASC and is delivered in a wide range of ways including an innovative Early Intervention Project, a commissioned Early Intervention and Prevention Service and through a range of information and advice (see theme 2). There has been significant investment in prevention through our new Target Operating Model which at a time of financial constraints, prioritised ASC and

	prevention and saw the establishment of Strengths Based Practitioners in the service.
Working in Partnership	Partnership working is a key principle of our Strengths Based Approach (see theme 2). There is good partnership working with local health partners, commissioned providers and other stakeholders. Despite its size, the ASC team has to build relationships and partnerships across a wide breadth of partners. Innovative responses such as the Care Navigator post which provides links between several acute hospitals, GPs and social care helps facilitate some of this partnership working.

Workforce

Our ASC Team is a generic team of experienced practitioners with good rates of retention. The Team includes Social Workers, Occupational Therapists and Strengths Based Practitioners. The Strengths Based Practitioner roles were introduced as part of a new Target Operating Model and reflected the organisation's commitment to Adult Social Care and prevention in a context of financial constraints. These innovative roles are designed to support people at the edge of care with short term interventions to improve wellbeing and delay the need for care.

Caseloads in the team are manageable and are managed dynamically, taking into account complexity and aiming for under 20 cases per social worker (this can include assessments, support planning and reviews). This gives staff the time to develop positive relationships with residents to enable effective and ongoing assessment of need and subsequent care and support planning.

Within the team, there are designated champions who act as expert leads in certain areas such as carers, dementia or transitions. These champions keep up to date with current good practice and engage in local and national partnerships and support peers to develop in these specific areas. This is also designed to help support development of leadership skills.

An ASC workforce development plan for ASC has recently been updated to ensure it is fit for purpose and meets needs. Social Workers have access to a wide range of training, both internal and external and over the past year have attended training on applying the legal framework of the Mental Capacity Act and the need for speed to discharge people safely, Safeguarding Adults Level 3, Motivational Interviewing and Making Every Contact Count. Recent team wide training has focused on development of the Strengths Based Approach and the specific skills required for this.

ASC has recently appointed a dedicated Principal Social Worker (PSW) as a standalone role, rather than it being embedded into the Head of Service role, to strengthen practice governance and staff development amongst other things. The Principal Social Worker is consolidating some of this skills-based training noted above.

A survey of the children's and adult social care teams was undertaken in September 2022, based on the Employers Standards. Though feedback was generally positive, an action plan has been developed (across both services) to consolidate reflective practice, career development and improved induction for new staff (this is also reflected in a wider corporate commitment as part of the People Strategy).

Case Study – Feedback from Staff Survey (Survey, September 2022 and Suggestions Box, January 2024)

How do we respond to staff concerns and suggestions?

Staff feedback: *"Being part of such a small stable team, has lots of positives but also challenges. New **ideas**, ways of working, wider conversations are less likely to happen. It's important to keep practice current and alive rather than falling back on our 'uniqueness' which can sometimes stop changes in our practice to align ourselves with the London LA's."*

We listened:
We now have full-time stand-alone post of Principal Social Worker, and our Senior Occupational Therapist is a member of Principal Occupational Therapists Network. These practitioners enable local and national networking, share policies and guidance, and make improvements to our processes and practice.

We also have a "Staff Suggestions digital box" system, where our staff can make positive suggestions and share their views, and we learn from our Exit Interviews, which are reviewed by the Principal Social Worker.

We invite external guests and speakers to our events, to boost our engagement in ASC national and local agenda, such as at World Social Work Day or visit by Chief Social Worker, Lyn Romeo.

Staff feedback: *"I think there is a well-balanced understanding of case workload and stress. I feel listened to and understood, for example if I ask for a little space/time to finish off work before new cases are allocated."*

We listened:
We also review themes shared as positive feedback to ensure we maintain good mental health of our practitioners.

An anonymous staff comment through our Suggestions Box: Response to question what we can do to improve our work: *"A total review of ASC proportionality of roles and how work is distributed."*

We listened:
Principal Social Worker (PSW) addressed the issue of allocations and how work is distributed with the Head of Service (HoS). Agreed and shared with the team an action for PSW and HoS to review the allocation and distribution of long-term and short-term cases, safeguarding work and other tasks. At the same time managers updated case allocation Case Note template on Mosaic to include specific information about the case, its complexity, timeframes, and expected tasks, which can help practitioners to manage caseloads better.

Supervision plays an important part in supporting and developing our workforce and our commitment to this is demonstrated by:

- The development of a new supervision protocol and new supervision forms that include a reflective approach
- Auditing supervision as part of the annual audit schedule and annual staff survey
- Establishment of new peer group reflective supervisions, held once a month on complex case studies using a reflective model

Other support is provided to social workers around wellbeing including an Employee Health and Wellbeing Hub and various team wellbeing tools. There is also guidance for Managers in the Team about how to support wellbeing. Social Workers also have access to the PSW for individual practice improvement sessions or wellbeing support.

The City Corporation has joined the South East London Teaching Partnership (SELTP) which brings together Goldsmith and South Bank Universities, Royal Borough of Greenwich, London Borough of Lewisham, London Borough of Southwark and now the City Corporation. The SELTP's ambitions align with the Department for Education's vision for teaching partnerships and aim to raise standards in children and adults' social work by supporting high-quality training for social work students and qualified practitioners.

ASC supports students on regular basis, which enriches practice with their academic research, social work models and theory. Having a social work student in the team has a positive impact on the workforce, enhancing motivation and enthusiasm levels. At the same time we embrace our partnership with academia and contribute to developing the social work profession.

Working in Partnership

Working in partnership has been a key approach in our work over recent years but is specifically strengthened in the Strengths Based Approach practice model.

There are good working relationships with the one NHS GP practice in the City of London and the relevant GP practices in Tower Hamlets. A social worker or the Care Navigator attend the Multi-Disciplinary Team meetings at these practices.

The City Corporation is part of the North East London Integrated Care System which provides some benefits as it includes Tower Hamlets where 16% of our residents are registered with a GP and access health services. As noted above, the pathways for delivery of health services and therefore integration are complex for the City of London.

More locally, the City Corporation is part of the City and Hackney placed based partnership, reflecting our previous partnership with City and Hackney CCG. This local partnership is well developed in terms of integration and has a neighbourhood model for care closer to home and out of hospital services. It is underpinned by a principle of tackling health inequalities. Primary Care Networks across City and Hackney mirror the eight neighbourhoods across City and Hackney. Our unique situation and different infrastructure means that often bespoke models for integration have to be developed for us, for example in the neighbourhood.

At the neighbourhood level, social workers are active members of the Multi-Disciplinary Meetings which are designed as a space for complex cases to be considered, owned as a group and lead organisation agreed. A number of City of London cases have been taken here and this has been beneficial in terms of partners being accountable and taking responsibility for certain areas of work.

There are a number of new roles emerging within the neighbourhood structure such as care co-ordinators, health and wellbeing coaches and Care Co-ordinators for proactive care. Community

Mental Health Services have also been re modelled on to neighbourhood footprints with Community Connectors. The Service is proactive in making connections with all these roles to ensure that City of London needs are recognised and responded to and that services work for us.

The voluntary and community sector in the City of London is small but vitally important for our residents and our practice model. There are two key voluntary sector providers of large contracts – a City Advice Service provided by Toynbee Hall and an Early Intervention and Prevention Service (known as City Connections, provided by Age UK). It is recognised that there are other smaller VCS groups providing support within the community and there is work currently underway looking to build the capacity and scope of the VCS in the City of London to play an ongoing role as key partners. There is also a strong Healthwatch organisation within the City of London.

Our Care Navigator, who is part of our Early Intervention and Prevention Service, plays a key role in building partnerships between acute hospitals, GPs and ASC to facilitate safe hospital discharge from a number of hospitals that City of London residents attend.

There are strong relationships with our other commissioned providers such as the London Borough of Hackney who provide our out of hours service, the East London Foundation Trust who provide our Approved Mental Health Practitioner (AMHP) Function and the providers of our reablement and rapid response service.

Having external providers for these services ensures capacity and continuity of service and in the case of the AMHP, ensure there is appropriate clinical supervision and embedding within a relevant discipline.

CQC Theme 1: Working with People

Our Strengths

- Experienced and knowledgeable workforce (managers and staff with good rates of staff retention) and a workforce who know our residents well and develop positive relationships
- Strengths Based Approach Practice Model
- A co-ordinated, multi-agency approach to the assessment and support of our residents

Areas for Improvement and Direction of Travel

- Continuing to strengthen our Strengths Based Approach practice model
- Exploring timeliness and impact of assessments and reviews
- Capturing and recording equalities data more effectively and using this to shape services
- Improving the quality and accessibility of our information offer for residents

Key statistics

181 Residents requesting support from ASC services (2022/23) **94** April – December 2023	**49** Supported Self-Assessments (2022/23) **33** April – December 2023	**31** Occupational Therapist assessments (2022/23) **38** April – December 2023
8 New Carers Assessments completed (2022/23) **10** April – December 2023	**0** % waiting more than 6 months for an assessment (any assessment) (April – December 2023)	**64%** **(37 cases)** % ongoing reviews completed within 12 months of previous review (April – December 2023)
	26 Receiving a Direct Payment 31 December 2023	

ASC operates within the People's Directorate which includes Children's Social Care and rough sleeping. It also works closely with the Education and Early Years Team who sit within the Education Unit. This enables cross-cutting work across, for example, transitions or homelessness. There are monthly People's Senior Management Team meetings (which also includes Education and

Early Years) where various policies and initiatives are discussed, and cross-cutting work is identified or reported back on. There is also a complex cases meeting where teams from across the Peoples Directorate bring their most complex cases and teams work together to share ideas and good practice and identify if / where they may need to be involved.

A Strengths Based Approach Practice Model

The ASC Team use a Strengths Based Approach Practice Model which was implemented in 2022 and is designed to support people to maintain their independence and meet their outcomes and aspirations. The model is built on:

- Working in collaborative ways on mutually agreed goals
- Using the community as a resource
- Having trusted and workable relationships

Empowering residents through preventative measures and clients through our assessments, service planning and delivery is a key tenet of our approach. This includes:

- Working together on assessments to ensure that the individual is able to identify and express their outcomes
- High rates of Direct Payments. In 2021/22 placed 28th out of 151 Local Authorities for direct payments)
- Service users are part of various commissioning cycles for example for the Homecare Service which was recommissioned throughout 2021. This was co-designed with service users, carers, Healthwatch and City Connections. Stakeholder feedback was used to understand service priorities and needs, which shaped the service model and specification, the procurement approach, and the design and scoring within the tender.

The ASC service meets the Care Act duty to prevent, delay or reduce needs wherever possible in a variety of ways including Occupational Therapy, Reablement, Commissioning and Social Work Practice, all set within the wider context of a strengths-based approach across the service.

ASC developed an innovative Early Intervention Service which is a pot of funding that empowers ASC practitioners, together with a resident, to identify and implement low-cost one-off interventions which help improve wellbeing and in turn prevent, reduce or delay needs. This has included things like a microwave so that someone was able to have hot food to eat, a zoom licence to reduce social isolation amongst unpaid carers and fishing equipment to help improve mental health. During an 8-month pilot period in 2022, 26 individuals were supported, and 46 purchases were made costing a total of £5,288. All the people supported in the pilot had identified social care needs but were considered to be 'at the edge of care' in relation to the meaning of the Care Act. Of the 26 people supported, none were receiving costed social care support and in all cases no care needs increased.

The pilot has now been made a permanent service. Work has now been undertaken within our system to report more systematically on the impact of the intervention and evidence is now showing that there is greater take up and confidence in the use of the fund by social care practitioners. One practitioner noted:

'*Having the support from management to use my initiative and listened to what would actually be helpful to the service user, led to improved outcomes for clients and improved relationships. I could show to clients that we actually do want to help in a person-centred way and prioritise what they need to make meaningful change'.*

The City Corporation also commissions an Early Intervention and Prevention Service called City Connections. This is provided by Age UK and includes a signposting service, a general wellbeing support service and a specific memory café for people with memory issues and their carers. Recently, a specific carers support service has also been provided through a sub-contract (see Theme 2).

Case Study – working in partnership with the voluntary sector.

The Carer is 40 years old, caring for a parent-in-law and lives in a small household with 4 other family members. They are linked in with the City Connections service commissioned from Age-UK by City of London. The Carer reports that the caring role can sometimes be frustrating, and they feel they do not have time for themselves. In addition, the Carer does not use English as their first language and can sometimes find it difficult to access services.

As a result of living in a small space, it was important that the Carer was provided with opportunities to have break from their living situation by encouraging them to join as many community activities and trips as possible with one of our community groups. City connections took into account the Carer's religion and culture when planning these with them.

The Carer took part in many of the organised trips, such as Hampton Court, Kensington Palace, Sky Garden, and Buckingham Palace. They said that they enjoyed the outings very much as it enabled them to see places in the city. The carer was able to go out with people from the same estate and it helped them make new friends.

The Carer also accessed the exercise classes and commented, **"The exercise we do is hard, but when I go home, I feel good. I like that the classes are every week, whereas before when it was only two times a month."**

City Connections linked in with another City of London commissioned service, City Advice, to provide an information session. The whole group were actively engaged in the topics being discussed. This particular Carer engaged with City Advice advocate coordinator, who speaks the same language, and they talk about issues with housing and the support they would like to receive.

This was a good example of voluntary services working together, City Connections providing the space and audience for City Advice to do their work and it has shown how important multi-agency can be for residents in the City of London.

The ASC service has also developed innovative winter warmth packs and summer cooling packs to respond to cost-of-living pressures and extreme weather. These are given out by the Strengths Based Practitioners and include things like fleeces, cuppa soups, a small fan and jelly drops which help with hydration.

Case Study – Strengths Based Practitioner Support

A resident described our Strength Based Practitioner as outstanding saying: **"she has an outstanding gentle, step by step approach to making progress in a friendly way".**

The Adult is a 74-year-old and had a number of medical conditions including persistent pain, weight loss and a skin condition. There was a general lack of strength to cook and care for themselves and concerns over possible self-neglect.

The Strengths Based Practitioner's intervention was planned with the intention of re-establishing a personal care routine, support with setting up a self-funded package of care with a previous provider. The practitioner enabled the Adult to build back their personal care routine and improve skin condition. This was achieved through going through the skin care procedure together, setting up a system of text prompts to remind the Adult to carry out the skin care routine regularly and then visiting again to check in.

This resulted in improving their general wellbeing and self-confidence. The adult reported in their feedback that they had benefitted from the intervention and that they felt more independent because of it.

Following the intervention and final visit, the Strengths-based practitioner arranged for a social worker to visit as the adult wanted to discuss future options around potential private residential care.

Case Study – Strengths Based Practitioner Support

The Adult had been married for over 50 years until their partner passed away 2 years ago. They had kept themselves to themselves, not been known to local services and were not registered with a GP. The property was very cluttered and the adult, who is in their 90s was very reluctant to engage with Adult Social Care.

The Strength Based Practitioner engaged with them on weekly basis via telephone and in person building a relationship learning about their history, estranged family and love of Jazz. SBP persevered over an extensive period of time and despite initial reluctance the adult began to discuss the risks in the home with the SBP and agreed to suggestions on how to mitigate these with equipment and support at a level acceptable to them.

The SBP also supported him to access a GP and navigate the phone call system.
The Adult is now more excepting of care and support and engages with ASC, equipment and telecare have been installed, and domestic home care support is in place, which keeps him safe, independent, and living at home. They are now registered with a local GP and engages with the surgery, is more confident and has made contacts & friendships within the local community.

The SBP used the Eary Intervention pathway to provide a fan during the heatwave and a fire safe heater for the cold weather.

The Adult said that the SBP had been wonderful & they didn't know what they would have done without her. They reported that he has regained confidence due to the SBP encouragement, reassurance, and support.

Case Study – Social Worker support

The Adult came to the UK in 2022 as a sponsored refugee from Ukraine and presented to the City Corporation as homeless, unable to speak English and with possible care and support needs. At that time, they were supported by a daughter who was caring for them.

Our work focused on needs and risks, for both Adult and Carer, while enhancing their independence and resilience. The social worker completed a Care Act Assessment, assisted with applying for sheltered accommodation and helped to access a range of different grants (for clothing, furniture, bedding, and kitchen items). Reablement support was provided followed by a longer-term package of care. The Adult and their Carer were both referred to City Advice, for assistance with a benefits review. A Carers Assessment was offered several times. Social Worker guided both through our processes and understanding of relevant legislation, offered advocacy when needed, and emotional support, time, and empathy.

Information was given to the daughter about Ukrainian groups, befrienders, churches, and church groups.

The adult's anxiety and depression began to improve, and the number of panic attacks reduced. Her needs stabilised and they are now independently accessing their local community, supermarket, and shops.

They moved into sheltered accommodation in another local authority, and while it took time for the adult and their daughter to access the appropriate benefits the accommodation is now stable. They have a lot of phone contact with their extended family, and they occasionally go and stay with a sister, who lives outside of London.

<u>Feedback from the daughter of Adult with care and support needs (10.05.2023):</u>

"I just want to express my heartfelt appreciation for all the support and assistance you provided to me and my … (parent) during one of the most difficult times in my life. Your unwavering dedication and commitment to helping my … (parent) and me through our struggles were truly invaluable. I will always be grateful for your guidance in funding resources and solutions that were tailored to my …(parent's) unique situation! Your expertise in navigating the complex web of services available to my ...(parent) was a true blessing, and I am confident that I would not have been able to find my way without your help! I want to commend you for your professionalism, kindness, and dedication to helping those in need. Your passion for helping others truly shines through in everything you do, and I feel incredibly lucky to have had you as my …(parent's) social worker! Thank you! You have made a lasting impact on my ...(parent's) life, and we both will be always grateful for your support."

Within our practice model, the Strengths Based Approach is operational from first contact. Rather than 'screening out' at the front door, practitioners are expected to be 'helping out' with information, advice and signposting. ASC are the main referrer to the City Connections service which supports people to access some of the services signposted to.

A commissioned information and advice service (City Advice), covers a range of issues and provides advice to residents and workers in the City of London along with our tenants in housing in various London boroughs. Part of the specification for the service includes some of the basic information and advice about accessing social care services. During 2022/23, there were 27 requests for this information. Our carers webpages were recently reviewed with carers and updated to make them useful and user friendly. Other ASC service pages are currently being reviewed to ensure that information is most relevant and user friendly.

Our mechanisms for feedback and how people's outcomes from the service are measured are currently being strengthened (see theme 2).

Assessments

The service uses a supported self-assessment model for assessments and there is an expectation that timeframes are responsive to the needs of and risk to the individual and their family. They can also be impacted by other factors such as the need to discharge someone from hospital. There is an expectation in our practice standards that assessments will be completed within 30 days, while our current reporting uses an indicator of 28 days. We will review and align these targets. Where assessments are more involved, discussion around this would take place within supervision.

Summary

- Our ASC workforce is experienced with good rates of retention and with manageable workloads allowing presence and time for strong relationship building as a core of our Strengths Based Approach
- The generic nature of the team allows for a flexible and agile approach and a more holistic view of the person
- A new Target Operating Model for the City Corporation recognised the importance of Adult Social Care and of prevention and as a result a new innovative role – Strengths Based Practitioner was developed
- A new standalone Principal Social Worker Post is in place which will allow for the strengthening of practice assurance and personal development
- Working in partnership is well established but is strengthened within our Strengths Based Approach
- There is active engagement with our place-based partnership and within this, the neighbourhood model
- Relationships with the voluntary sector are strong but the voluntary and community sector in the City of London is small. This is an area for development
- Strong relationships with health providers provides a base for working in a co-ordinated and multi-agency approach to assess and support residents (see also theme 2)
- Our approach to service delivery is person centred and empowering, but it is recognised that feedback mechanisms and measurement of outcomes from our work need to be strengthened

CQC Theme 2: Providing Support

Our Strengths

- A strong hospital discharge model
- Agile and flexible approach with the ability to spot purchase to meet needs
- Well established integrated care models locally and established relationships with health and Voluntary and Community Sector organisations

Areas for Improvement and Direction of Travel

- Improving the timeliness of reviews
- Improving triangulation of quality assurance of services
- Strengthening collection of feedback and measures of outcomes from service users

Key Statistics

21 Receiving domiciliary care directly on 31 December 2023	**26** Receiving a direct payment on 31 December 2023	**23** Living in supported housing on 31 December 2023
1 Using Day Care on 31 December 2023	**18** Living in residential care on 31 December 2023	**7** Living in nursing care on 31 December 2023
	14 Received a Reablement Service April – December 2023 **92%** those over 65 who required less support following a period of reablement April – December 2023	

Agile and flexible approach to meeting needs

Our approach to commissioning services is set out in our Market Sustainability Plan, and our Market Position Statement is emerging. Our strategic commitment is to support people to remain at home, which shapes demand for homecare, also informs a more complex need, and costly delivery when a placement is required.

The City of London has no accommodation-based support within its boundaries other than a sheltered accommodation unit which is provided by a housing association.

There has been a consistent level of demand for residential and / or nursing home care over the past 5 years. It is expected that at any one time there would be 20 – 25 placements in place, with an annual placement rate of around six to eight. The growth and ageing of the resident population have not led to a corresponding increase in demand for residential care provision.

As part of the ASC Transformation Programme, a project around brokerage is currently underway. This is designed to make our processes around commissioning residential, nursing and supported living placements more robust, to increase the strength of quality assurance and to ensure that all information on placements is triangulated through our social care system, Mosaic.

There is one commissioned homecare provider and a number of people who have a direct payment to purchase their own provision – some people chose a direct payment when the homecare provider changed, and they wished to remain with the previous provider.

Rough Sleepers

There has been an innovative approach to supporting rough sleepers with a permanent social worker post within the homelessness service but with professional supervision from the Head of ASC. This brings knowledge and expertise to working with a cohort who experience some of the highest health inequalities and poorest outcomes. Our work with rough sleepers involves strong engagement with outreach and mental health services to support and inform effective assessments.

As part of our approach to meeting the needs of rough sleepers, a complex needs hostel for City of London rough sleepers was established in partnership with a homelessness charity and a neighbouring local authority. This year, a specific rough sleepers assessment centre to bring together all our assessment services into one physical place will be opened. The Rough Sleeping Social Worker will have strong links into this assessment centre.

Case Study – Rough Sleeping Social Worker

An adult was rough sleeping in and around the City of London for 15 years prior to the pandemic. They made a claim for asylum, but this was declined.

The Adult was experiencing a mixture of mental and physical health problems and was assessed as having care and support needs under the Care Act (2014) and that the local authority had a responsibility to offer support under the Human Rights Act (1998). Following an Occupational Therapy assessment, temporary accommodation was organised.

The adult had a care package of support, which over time was reduced and later discontinued, as they readapted to living independently and their mental and physical health improved.
Our Strengths Based Practitioners supported the adult over time, building their confidence and relationship within the local community and with services.

The strengths-based practitioner helped him look into aspirational training courses which he had identified, such as security and forklift driver, following his lead to help him work out what he can and can't do rather than shutting doors. They also supported him to attend the local library to use their computers, so that he can do his own research.

The adult appealed the previous asylum decision, and in summer 2023 was granted asylum status in the UK. Now with our support they are building a new life. The adult is being supported to present as homeless and it is hoped that they will soon have an option to move into a property provided via the statutory homelessness pathway.

Adult's views/ comments:

The adult says that their community – the GIANTS group with Praxis, the British Red Cross group, and the African Rainbow Family – have all given them "a sense of motivation and encouragement even when times have been hard". They say that it is something they really value and enjoy. The adult has recently been in the GIANTS group's published cookbook talking about food they enjoy. GIANTS group with Praxis is a peer group for men applying for asylum, the British red cross is a similar resource, and African rainbow family is for people originally from Africa who identify as LGBTQI+. These groups have given the adult a sense of community and belonging, and motivation when times have been hard.

The adult also reported that Homelessness and ASC staff working with have been like 'therapists' and added: "I am not good in a crisis" and "a problem shared is a problem solved", as an appreciation of being supported by us.

Carers

The ASC Team were supporting 33 carers at the end of December 2023. All carers' assessments are carried out by social workers ensuring that carers assessments are carried out with a high degree of expertise and support plans are developed together. Carers receive individual budgets in the form of a direct payment to meet individual need, and these are not means tested.

In October 2022, an internal audit was carried out to assess the quality of carers assessments. Findings were largely positive with carers reporting a good overall experience with some recommendations for improvement. This included developing a toolkit for practitioners to improve consistency in approach to assessments and a guide for carers outlining what to expect before, during and after the assessment to help improve both experience and outcomes. There was also a recommendation for management to strengthen monitoring of carers assessments including monitoring of annual reviews to ensure timeliness and avoid slippage.

Initially, general wellbeing support for carers was provided through a commissioned early intervention and prevention service (City Connections). Following engagement with carers, it became evident that there was a need for a higher level of specific support for carers. This was piloted and will now be continued as a standalone service.

The Carer Connections service has been running since October 2022 with a dedicated Project Manager, through the Tower Hamlets Carers Centre. Initial work reflected the national picture that there are a significant number of hidden unpaid carers in the City of London who may not recognise themselves as a carer, and who are not in contact with a carers support organisation. A creative approach to community outreach identified 45 new carers, 51% who identified as being from a Black and global majority background and 49% who live on the east side of the City of London. This has been a significant area of focus for us.

Feedback from carers who had used the service showed an average score of 6.1 / 10 that they are consulted and co-produce the services delivered for them and an 8.2 /10 that they can stay independent and get help when they needed it.

A new Carers Strategy is now in place and to inform this, an innovative peer researcher approach was used to gather the views of carers which allowed us to reach a wider range of carers than usual.

Hospital Discharge

The number of hospital discharges the service has supported has increased since the pandemic but more significantly, so has the complexity of these cases as people are discharged more quickly. During 2022/23 102 hospital discharges were supported by the service (86 April – December 2023).

There is a strong model of services around hospital discharges including the Care Navigator who supports safe hospital discharge by building bridges between services, a rapid response service who can provide intensive care and support for short periods to facilitate discharge to assess and to prevent hospital admissions in the first place, a commissioned reablement service and an in-house Occupational Therapy team. There is also close working with health services such as therapy services.

The City Corporation discharge model is designed to best meet local need. Since April 2020, weekend discharge activity represented just 0.02% of overall discharges and therefore a fixed 7-day discharge service was not appropriate. The approach is built on the following:

- A full discharge service operates during normal working hours of Monday to Friday 9-5. A clear expectation is set for the service to work flexibly outside these hours, subject to demand and need
- Friday pressure points are expected, which may require ASC cover outside of normal hours; allowing weekend discharge arrangements to be secured
- The City Corporation's Rapid Response Service provider can support pre-arranged weekend discharge
- Bank holidays will not typically be covered, however, cover arrangement requirement will be assessed and responded to, with cover provided based on discharge demand and 'in hospital' figures. The ASC Head of Service provides the final decision on the requirement of responsive weekend cover
- Placing significant emphasis on prevention and early intervention in relation to safeguarding
- Ensuring that appropriate actions are taken where there is reasonable cause to suspect that an adult with care and support needs is at risk of abuse or neglect

Our Better Care Fund Plan is the primary source of funding for most of our hospital discharge work.

Case Study – Hospital Discharge, Care Navigator

The Care Navigator from Age UK worked with an Adult in hospital who had been struggling at home for some time but had been reluctant to ask for help and to share information. However, working with the Care Navigator, the individual wanted to be fully involved in their discharge planning but had a difficulty hearing, so by using email, they were able to provide more information about needs and requirements to help with the discharge home.

The Care Navigator acted as a bridge to adult social care to create positive outcomes for the adult by ensuring equipment such as key safe and pendant alarm were in place to prevent delays and ensure a safe discharge. The hospital did not provide a discharge summary for the Adult, but the Care Navigator ensured relevant details were shared with the GP including the arranged outpatient appointments.

Despite the level of complexity, the work of the care navigator helped facilitate a whole range of organisations working together to support the adult home safely and to meet their needs.

Feedback from the Adult

The Adult said they were proud of their independency and had not had to rely on social services for support before, but, as they said: "things are getting difficult for me now".

The person continued: "I have a hearing problem so using the phone is difficult, but I like using iPad", so they asked the Care Navigator to inform ASC to contact them directly about future discharge to help if access home visit was necessary so "I can point things out things I am concerned about".

The Adult shared that they enjoyed "computers and music in the past, like the trombone and guitar, but these have become more difficult to do now".

During a follow up meeting with the Care Navigator the Adult expressed their anxiety around the home environment being ready for their discharge and their wish to be fully involved in the discharge planning.
The Care Navigator spoke to Adult Social Care Duty on their behalf and a social worker was allocated, instead of managing the discharge through the duty team. The social worker visited the Adult in hospital and completed joint home access visit with an occupational therapist, ensuring the Adult was fully informed and in control of their own discharge.

Learning Disabilities

There are currently 12 adults with Learning Disabilities open to the adult social care team, 1 is aged under the age of 30 and the rest are aged between 30 and 60. 4 live in their own homes in the City of London (2 with family) 1 lives in residential care and 7 live in supported living setting.

There is a joint Learning Disabilities Service in the London Borough of Hackney which brings together the Local Authority and health services for Learning Disabled people together. City of London residents with Learning Disabilities are able to access the health services through this model.

Transitions

The ASC Team are part of a Transitions Group with the Education and Early Years Service and Children's Social Care. A register is kept of children and young people who will need to be reviewed to assess whether they need to transition to ASC services. There is also an ASC social worker who is a champion for transitions cases.

There have been very few transition cases in recent years, but these have been well planned from the age of 14 (through the Transitions Group) and have been a smooth transition.

Summary

- There is an agile and flexible approach to meeting need with spot purchasing, direct payments and innovative approaches
- In responding to the complex needs of rough sleepers we have a homelessness rough sleeper who has had excellent results in providing person centred approaches and linking up with specialist services
- Hospital discharges have become more complex and in response, a new hospital discharge model was developed to meet government requirements. This is supported by our Care Navigator who supports safe hospital discharge and acts as a bridge between partners
- Carers have been a specific area of focus for us over the last couple of years with an audit on carers assessment and associated actions and the development of a specific carers support service

CQC Theme 3: Ensuring Safety Within the System

Our Strengths

- Strong City and Hackney Safeguarding Adults Board with multi-agency support and commitment for safeguarding; but with a distinct focus on City of London through a separate Sub-Group
- Robust and rapid professional response to safeguarding concerns, incidents and provider issues, ensuring safe and personalised responses
- Safety built into all levels of the system

Areas for Improvement and Direction of Travel

- Implementing robust and routine feedback from people who have been safeguarded
- Safety challenges around the Cost-of-Living Crisis and Rough Sleeping
- Responding to the complexity of hospital discharges

Key Statistics

50 Safeguarding concerns inside COL (2022/23) **31** April – December 2023	**24** S42 Enquiries (2022/23) **16** April – December 2023	**29** S42 conclusions (2022/23) **18** April – December 2023
63% Of Safeguarding concerns were related to neglect and acts of omission and self - neglect (2022/23) **63%** April – December 2023	**21** Cases where outcomes were expressed (2022/23) **15** April – December 2023	**86%** Percentage of outcomes that were fully or partially achieved (2022/23) **87%** April – December 2023
24 Number of cases where risk reduced or removed (2022/23) **12** April – December 2023	**5** Number of MCAs which took place (2022/23) **2** April – December 2023	**20** Number of clients with a DOLs in place on 31 March 2023 **25** 31 December 2023

City and Hackney Safeguarding Adults Board

The City and Hackney Safeguarding Adults Board (CHSAB) is a multi-agency partnership including statutory and non-statutory stakeholders. The role of the Board is to assure itself that robust safeguarding procedures are in place across City and Hackney to protect adults with care and support needs who are at risk of abuse and neglect. Where abuse and neglect does occur, the Board and its partners are committed to tackling this and promoting person-centred care for all adults experiencing abuse or neglect.

The CHSAB has been chaired by Dr Adi Cooper, architect of Making Safeguarding Personal, for more than five years which has provided strong and stable leadership around safeguarding locally.

The Assistant Director for People chairs the Safeguarding Adults Review sub-group for the CHSAB and although the City of London has not had any Safeguarding Adults Reviews for a number of years, a discretionary one was carried out in November 2022 in relation to a rough sleeper who died in the City of London. A multi-agency action plan is currently in place via the CHSAB and all actions for the City Corporation Homelessness and ASC teams have been completed. This led to a full review of our participation and engagement work with rough sleepers and the development of an innovative participation project with Groundswell which is now in place.

ASC has been proactive in reviewing any SARs from Hackney and nationally to consider and embed any recommendations where appropriate.

Case Study – Learning from Safeguarding Adult Reviews

Following two Safeguarding Adult Reviews in Hackney, a panel was established to provide a person-centred, timely and effective multi-agency response to situations where the person referred has been assessed as a high level of risk because of complex self-neglect, fire risk or other high-risk issues. The aim of the panel is to ensure that all relevant agencies work together to provide a co-ordinated and accountable response to the person's presenting issues and risks and to focus on the outcomes the person wants to achieve to the greatest extent possible given individual circumstances and risks.
The panel has strong representation from partners and oversees a whole range of interventions form long term therapeutic work with adults with hoarding disorder to short term preventative measures.

For example, in 2022/23 £1,790 was spent on fire prevention equipment for adults in the City of London, this included replacing fan heaters or other high risk portable heating devices with safe electric oil filled radiators, replacement of multiplugs with fused power boards, and provision of fire-retardant bedding.

The Chair of the panel (Head of ASC) also attends the City and Hackney Safeguarding Adults Board SAR group creating strong links between both groups and the ASC service. Following a fire leading to the death of a resident in March 2022 a SAR referral was made. While the referral was not adjudged to meet the SAR criteria, and the Coroner concluding the death to be the result of an accident, it has been agreed with the CHSAB independent chair to hold a discretionary learning review to examine how services across the City of London may be able to learn and improve from this.

In terms of work of the Board, the City of London have been active partners in this work. Historical work has included financial abuse and self-isolation and more recently a focus on the impact of the cost-of-living crisis.

The Board provides training for professionals in 3 key areas:

- Recognised safeguarding training at the required levels
- Specific training commissioned by the SAB relevant to the work it is doing
- SAR learning events

To ensure that there is sufficient focus on the City of London, there is a City of London sub-group of the Board which is again independently chaired by Dr Adi Cooper and includes more local City of London partners and providers. The role of this sub-group is to provide assurance, accountability and the sharing of good practice in relation to the City of London. It considers City of London specific data and priorities in the Board's workplan.

Robust and rapid professional response to safeguarding concerns

The ASC service has a personalised approach at the forefront of its safeguarding work, alongside the assessment and mitigation of risk. These principles are applied equally to the proportionate responses taken to those concerns not meeting S42 enquiry criteria.

As with other London local authorities, the Service applies the London Safeguarding procedures. It is also familiar with Transitional Safeguarding and Joint Working with Children and applies these to support a smooth transition to adulthood.

Within the Team, social workers are qualified to undertake Mental Capacity Assessments and the AMPH, who is provided by the East London Foundation Trust, carries out any Mental Health Act Assessments as necessary. Best Interests Assessments are spot purchased from an independent provider to ensure independence although several of our social workers have training in this to ensure an understanding within the service and a link to the commissioned provision.

Mental Capacity Act (MCA) Assessments and safeguarding are included in our schedule for annual audits.

A system wide approach to safety

The promotion of safety and the understanding and management of risk is embedded across all elements of the system, both internally and externally. This includes:

- A corporate Safeguarding Policy which sets out expectations for Members, Officers and commissioned providers around their role in safeguarding
- Regular safeguarding reporting to Members of the Safeguarding Sub-Committee
- Online Safeguarding Awareness Training across the organisation
- An early intervention project focused on prevention and improving people's wellbeing by keeping them safe in ways defined by themselves
- The Care Navigator who facilitates safe hospital discharge and links hospitals and GP practices supporting more informed hospital discharges and sharing of information to reduce risk
- The ASC Team Manager and Deputy Team Manager are embedded in the Neighbourhood Multi-Disciplinary Meetings

- Social Workers and the Care Navigator attend GP Multi-Disciplinary Team Meetings in the Practices where residents are registered
- The People's Directorate working closely together with ASC presence at all cross-service meetings and work together with colleagues to minimise risk and support safer and more informed transitions between services
- Working closely with colleagues in commissioning and having a quality alert process in place to pick up domiciliary care concerns that are below the level of formal safeguarding and ensure that these are resolved at any early stage and prevent harm. When clients are placed in supported living, residential or nursing care our aim to use providers who are rated good or above wherever possible. When alerts about safety arise, commissioning work with the host local authorities to assess risk. Performance improvement letters are issued where safety or quality is a concern
- Providing access and support to training for commissioned providers such as City Connections and involving them in our City Safeguarding Sub-Group

Summary

- There is a robust approach to ensuring safety that is built across the system including Members, Officers, Health Partners and Commissioned Providers
- Although our Safeguarding Adults Board is a joint one with Hackney, there is a City of London sub-group which is also Chaired by the independent chair of the Board to ensure appropriate focus on the City of London
- Responding to the complex needs of rough sleepers and hospital discharges continues to present a level of risk but our innovative responses have helped to reduce some of this risk
- Though there have not been any mandatory City of London specific Safeguarding Adults Reviews any learning from SARs in Hackney and nationally have been reviewed and responded to accordingly – for example with the establishment of the Hoarding and Self-Neglect Panel

CQC Assurance Theme 4: Leadership

Our Strengths

- Strong, stable political and officer leadership across the City of London Corporation, underpinned by robust and effective financial management including scope for innovation that supports ASC. The development of the Target Operating Model facilitated growth for ASC when there were corporate pressures to reduce budgets elsewhere
- Clear visibility and access of senior management within the Department
- Assistant Director of People's Services provides leadership across all relevant services

Areas for Improvement and Direction of Travel

- Work to increase diversity across the service, as part of wider organisational approach, to reflect our community
- Retain a skilled workforce who are constantly learning

ASC benefits from strong officer member relationships which provide accountability and direction. This is underpinned by an effective formal and informal governance structure.

Informal governance

The ASC Senior Management provide visible and supportive leadership to staff as well as wider health and care partnerships.

There are monthly ASC Management Team meetings as well as People Management Team Meetings which allows cross cutting themes and issues to be considered. There is also a complex needs panel for ASC, a Category Board for the Department and Adult Performance Meetings.

There is also an internal Integration Programme Board which consists of a range of relevant staff and provides the space for system partners to come and talk to us at the City Corporation about our involvement in certain integration initiatives as an efficient way of gaining our input rather than us attending multiple meetings.

Formal governance

The Community and Children's Services Committee is the committee which holds responsibility for ASC and its associated budget. There are regular meetings between the Chair and Deputy Chair of the Committee with the Director of Community and Children's Services and the Assistant Director of People.

Members on the Community and Children's Services Committee also sit on committee relating to the Integrated Care system, the Safeguarding Sub-Committee and the Health and Wellbeing Board providing a strong cross cutting approach to key issues. These all underpin our strategic decision making and include regular scrutiny of our performance data. The Health and Social Care Scrutiny meets 4 times a year and specifically includes social care items on each agenda. Recent items have included an evaluation of the early intervention pilot, hospital discharge processes and proactive care in the local integrated care system.

As noted under Theme 3, our Adult Safeguarding Board function is delivered jointly with the London Borough of Hackney. The Assistant Director of People chairs the SAR sub-group of the Board.

Although the City Corporation attends and participates in key ICS and place meetings, it does not hold any specific leadership roles within this.

Quality Assurance

There is a strong golden thread and connection from management to operational practice with annual direct observation of practice from the Assistant Director of People as well as the Head of ASC alongside that of the Principal Social Worker and operational management.

ASC has recently appointed a dedicated Principal Social Worker (PSW) as a standalone role rather than it being embedded into the Head of Service role to strengthen practice governance amongst other things. This is already having a range of positive benefits including:

- Keeping Social Work practitioners up to date with relevant developments on areas that link with their practice. This is done through a weekly bulletin and a weekly 5-minute reflection is also sent to the whole directorate for use across services. This has enhanced communication with the team and built a habit of reflective practice
- Enabling us to engage more widely across the PSW network regionally as well as nationally and learn from this to update our practice. Recently, the PSW has taken part in an LGA peer review in Bournemouth, learning from other LAs and bringing this good practice back
- Strengthening our approach to Quality Assurance with the development of an annual audit schedule and feeding back learning into the service and reporting to ASMT. For example, following the audit of carers assessments, a guide for practitioners was developed to strengthen the approach to assessments. This was based on direct feedback from carers.

It is recognised that quality assurance could be strengthened by the addition of some external quality assurance. This has been taken forward and the first round of external audit took place in October 2023. A full report is due shortly.

Using Performance Data

The Departmental Performance Team produce monthly performance scorecards for the service which provides Senior Managers and the service with intelligence and performance data to provide assurance that statutory obligations are being met, that any risks are identified and mitigated, targets are being met and any emerging trends or issues are identified. The monthly performance scorecard is discussed at an officer performance meeting in the service. A more detailed summary of safeguarding data is scrutinised at the Safeguarding Sub-Committee quarterly.

Performance monitoring identified that some reviews were not taking place within timescale and changes have been made to the Mosaic system to flag these up so that none are missed.

Across the Directorate, there is a move towards the use of more PowerBI dashboards. One is being developed for ASC and our strategy is that different levels of dashboards will be developed so that they can be used at the front line to support self-management of work and performance.

Leadership on diversity and inclusion

- The Head of Service and Assistant Directors attended Leadership in Colour Conference and reflections from this were discussed at the People's Senior Management Team meetings and the People's Equality Group

- A People's Equalities Steering Group who monitor approaches in this area and established a book club for staff to read and discuss the book Me and White Supremacy
- Anti-Racist Practice Standards have been introduced which are being considered section by section at Team meetings led by the Head of Service, Principal Social Worker and Team Manager
- Reflection and learning on good practice around recording people's diverse needs in our Care Act Assessments were included as part of internal training on the Strengths Based Approach
- During celebrations of World Social Worker Day in March 2023, Tricia Pereira was a guest speaker at the City Corporation. Tricia is the Co-Chair of the Department of Health Social Care (DHSC) Social Care Workforce Race Equalities Standards Advisory Group and is the co-author of Strength-Based Practice Framework and Handbook published by DHSC in 2019

Comment by Principal Social Worker.

"City of London Community and Children's Department's senior leaders monitor the impact our work has on safety and wellbeing of people in our community by leading various board meetings and forums, such as Transformation Board, People's Senior Managers Meeting (PSMT)or Adult Senior Managers Meeting (ASMT), reviewing complaints/compliments and feedback from our citizens and encouraging co-production.

They are interested in wellbeing and performance of our staff receiving regular updates and listening to staff concerns by utilising quarterly meetings between DASS and PSW and by establishing Staff Forum. Both of our Executive Directors, Judith Finlay and the Assistant Director Chris Pelham, and Head of Service Ian Tweedie take part in our quality assurance activities by undertaking Direct Practice Observations of our front-line practitioners, which is very well received by the workforce and champions core ethics and values of our profession.

Example from observation notes, by Chris Pelham, October 2023: "There were interesting dynamics in terms of the relationship between the couple. One of them was from Thailand and there was a lot of consideration given to the relationships between the family members. Maria (SW) demonstrated curiosity re. these family relationships and how they might impact in terms of where the 'power' sits within the wider family systems – i.e., wider family and not wanting his wife to go to Thailand without him/leave him at home. In doing this, Maria was considering both needs as the cared for as well as his wife the carer."

Our senior leaders are visible and easily accessible having their offices next to operational teams, often "doing the walk" speaking with individual staff, attending our larger and smaller events, such as World Social Work Day or opening of ASC Library.

As PSW I feel reassured that our senior leaders encourage culture of learning and partnership working while promoting wellbeing of the workforce."

Summary

- There is strong and active political commitment to ASC in the City of London
- Senior Managers within the Department are visible and accessible to staff
- Opportunities for staff to develop leadership skills are being rolled out with staff having the opportunity to be champions in certain areas and the PSW focusing on personal development with staff
- Staff undertake a range of training and reflective supervision is developing. There is always the opportunity however to ensure that staff are continuously developing
- There are several initiatives promoting diversity and inclusion amongst staff and within the service. Promoting more diversity amongst staff to reflect our community is a priority

Areas for Development – Summary

Area	Response / Activity
Strengthening triangulation around commissioned placements quality assurance	Undertaking brokerage project as part of Transformation Programme
Developing a stronger performance culture within the service	Power BI dashboards being developed which will be able to be used at different levels of the service including at the front line, to help staff manage their own performance Training planned for Social Work Teams on understanding the role of data and the importance of data quality. Ongoing training in use of Mosaic to ensure correct data is added in correct place Review of reporting and KPIs underway as part of the Transformation Programme
Strengthening Quality Assurance	An external quality assurance mechanism has now been added
Timeliness of Reviews	Traffic light system has been added to Mosaic system to flag reviews. ASC are working with performance and MOSAIC teams to address system issues leading to differing target dates being indicated. Work is underway with practitioners as a whole and individually to ensure timeliness of reviews. Options are being explored to capture reasons for delays in reviews taking place.
Capturing and recording equalities data more effectively and using this to shape services	Review of system and recording of equalities data has taken place and changes identified – will be taken forward as part of the Transformation Project
Improving the quality and accessibility of our information offer for residents	Review of offer underway as part of Transformation Programme
Strengthening co-production and collection of feedback and measures of outcomes from service users	Currently underway as part of the Transformation Programme. Also wider piece of Departmental work underway to look at our framework for

	engagement and co-production and a reward and recognition policy.
Implementing robust and routine feedback from people who have been safeguarded	Currently underway as part of the Transformation Programme
Increase diversity across the service to reflect community	Will be taken forward as part of Corporate wide approach

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NHS
North East London

Joint Forward Plan 24/25 Refresh:

Health & Well Being Board

02 February 2024

Agenda Item 9

DRAFT

Introduction and considerations for the NEL HWBBs:

- NEL ICB was formed on 1 July 2022 following the Health and Care Act 2022, and we published our interim Integrated Care Strategy in January 2023. This was followed by the Joint Forward Plan 2023/24, our first five-year plan.
- We are required to refresh the Joint Forward Plan (JFP) yearly, to reflect what we set out to deliver in the coming years.
- We heard from our partners last year that they would like us to engage with them earlier in the process. These slides outlines how we have structured our system planning process for 24/25 and where the JFP fits in, the steps we are taking to refresh the JFP for 24/25 as well as the main changes from the previous year.
- Our Places-based Partnerships have been developing their plans for 2024/25, of which an overview is included in the JFP 24/25.
- We have included an unedited first DRAFT of the JFP 24/25 as an appendix, to indicate the direction of travel. A further draft will be available by end of January 2024, with a final draft by end of February. The ICB Board will be asked to approve the JFP 24/25 in March 2024.

Considerations for the HWBB membership:

Within the context of our interim integrated care strategy, members are asked to:

1) note why the JFP refresh is being undertaken and the approach being followed in order to deliver a refreshed NEL 24/25 JFP by March 2024.

2) note the amended content proposed

3) review and comment on the first JFP 24/25 draft document (Appendix 1- Draft JFP 24/25)

Overview of system planning approach

The NEL system planning cycle has been divided into three steps:

1. integrated care strategy
2. delivery plan
3. operational planning

These are outlined below with related deliverables included below each step. These are not comprehensive but indicate some of the key activities underpinning each stage.

*reflect the NHS planning guidance and other NHSE guidance

Joint Forward Plan (JFP) Refresh for 24/ 25 - next steps

- Based on feedback and lessons learnt from this year's JFP development, we are now engaging with NEL System stakeholders earlier within the system planning cycle in order to ensure improved awareness and input to the 24/25 JFP.
- There will be annual refreshes of the JFP going forward in order to ensure that the document remains current. This JFP refresh continues to 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.

High-level timeline

24 November 2023
We asked all slide contributors to submit their initial draft plans for 2024/25 for the JFP, providing a summary list of projects, and resourcing requirements.

13 December 2023
A portfolio workshop will be held with leads from the system portfolios, Places, cross-cutting themes and enablers. We aim to develop greater cohesion between portfolios, identify any synergies or duplication we need to address, but also to allow everyone share feedback on each other's plans.

9 January 2024
We will ask for updated slides based on the feedback from the December workshop.

February 2024
By 23rd February, all JFP contributors will need to submit their final plans/ JFP slide input, ready for sign off via appropriate meetings prior to submission by end of March 2024.

Main changes from the previous JFP

As we published our first JFP on 30 June 2023, we propose to keep the 2023/24 structure of the JFP, with some minor adjustments, as outlined below. Where references are made to figures, these will be updated to reflect the latest position.

Main additions:

- New slides to ensure we cover:
  - all our strategic system improvement portfolios in addition to our four strategic system priorities
  - our Place plans
  - our six cross-cutting themes and
  - our enables
- We have also included new slides outlining:
  - what is important to our residents and how it impacts our plans
  - our successes to date
  - how we are developing a strategic outcomes framework to help us assess if we are having an impact

NHS
North East London

Appendix 1:

24/25 Joint forward plan - draft document

(Note: Not for wider circulation)

North East London Health & Care Partnership

NHS North East London

North East London (NEL) Joint Forward Plan - Refresh

2024 - 2025

DRAFT

ALL SLIDES WITHIN THIS PACK ARE DRAFT VERSIONS

1. Introduction

Introduction

- This Joint Forward Plan is north east London's second five-year plan since the establishment of NHS NEL. In this plan, we build upon the first, refreshing and updating 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 in this plan we describe the substantial portfolio of transformation programmes that are seeking to do just that. We have now also included new slides our cross cutting themes and each of our seven Place based partnerships.
- 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.
- Our Joint Forward Plan will be refreshed yearly to reflect that, as a partnership, we have continual work to do to develop a cohesive and complete action plan for meeting all the challenges we face together. We will work with local people, partners and stakeholders to update and improve the plan yearly as we develop our partnership, 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 increasingly 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. We 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 and 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

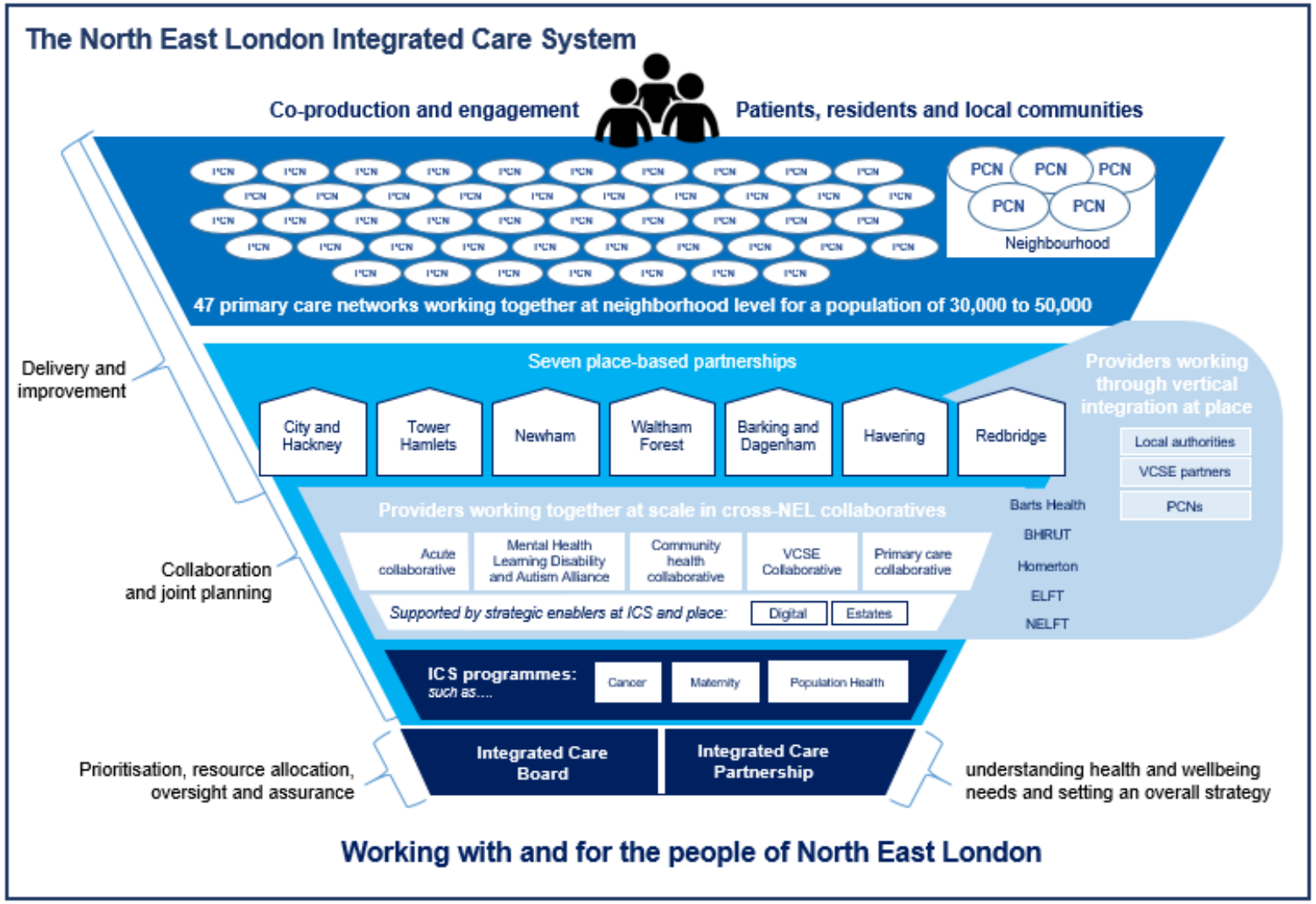
We are a broad partnership, brought together by a single purpose: **to improve health and wellbeing outcomes for the people of north east London**.

Each of our partners have positive impacts 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. As we build upon and increase our collaboration and integrated ways of working the opportunity for greater impact will increase.

Our partnership between local people and communities, the NHS, local authorities and the voluntary and community 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 on 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

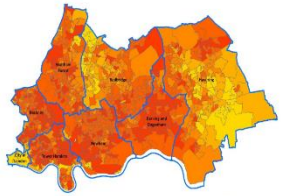
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from ethnic minority backgrounds.

Our diversity means a 'one size fits all' approach will not work for local people and communities, but there is a 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. 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.

What is important to our residents (Big Conversation themes)

PLACE

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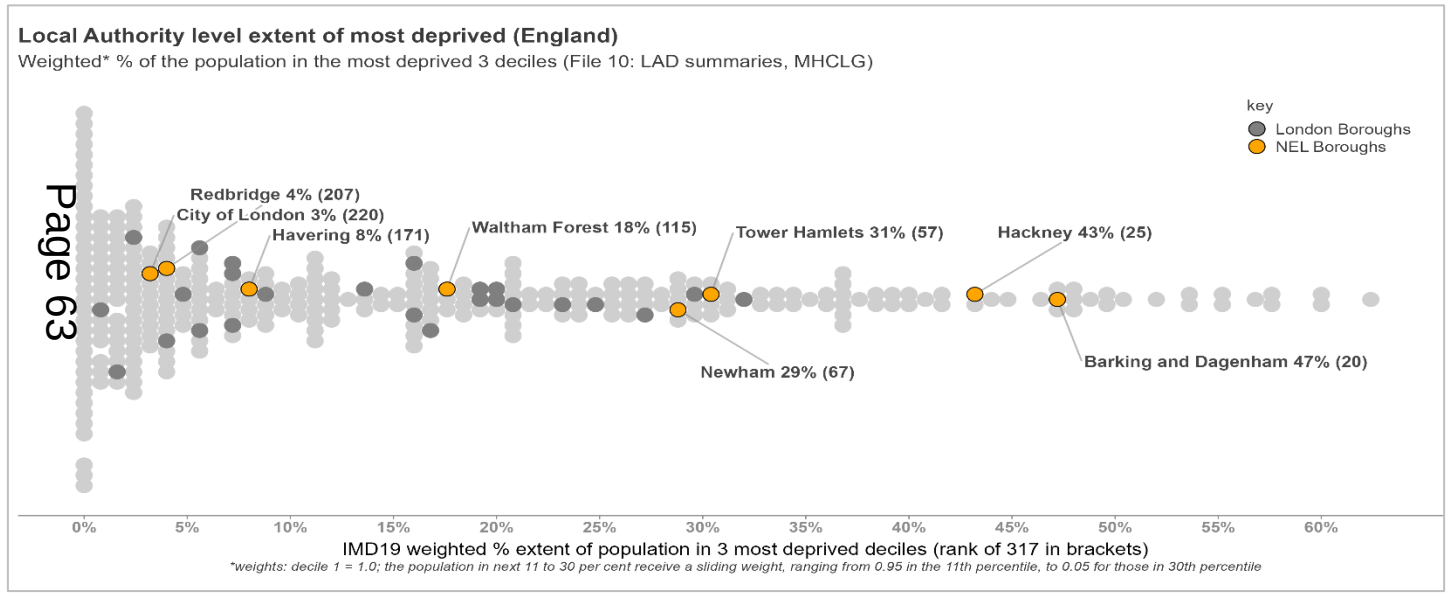
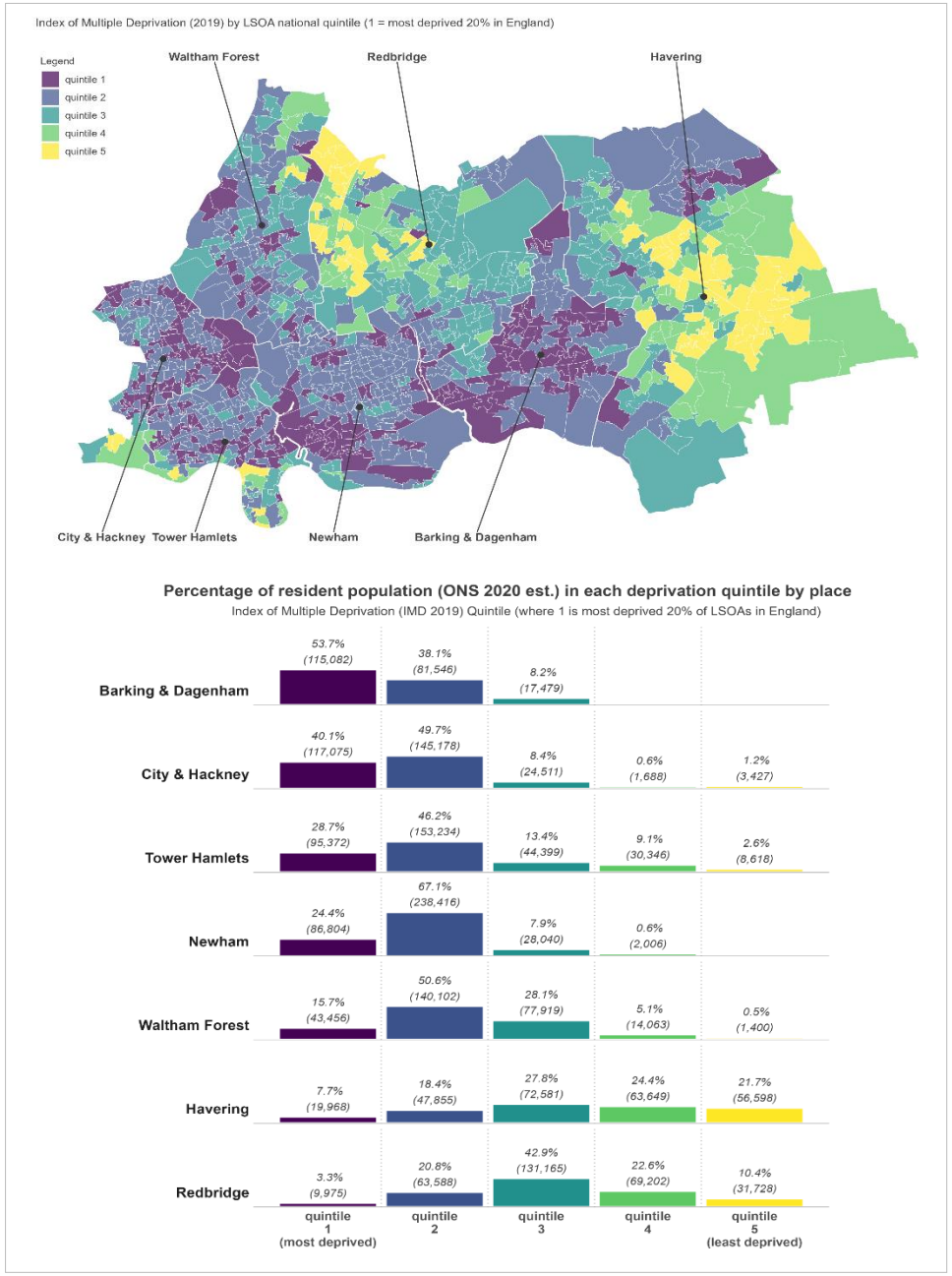
Key factors affecting the health of our population and driving inequalities - poverty, deprivation and ethnicity

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 and Dagenham (54%), City and 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 along with 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.

To meet the needs of our population 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

One in 20 pregnant women smokes 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 higher numbers of vulnerably housed and homeless people, including refugee and asylum seekers, 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 estimates in 2022 there were 42,399 homeless individuals in NEL inc. those in temp accommodation, hostels, rough sleeping and in social services accommodation. That's 1 in 47 people, compared to 1 in 208 people across England and 1 in 58 in London. People experiencing homeless have worse health outcomes & face extremely elevated disease and mortality risks which are eight to twelve times higher than the general population.

Childhood Poverty

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

Childhood Vaccinations

The NEL average rate of uptake for ALL infant and early years vaccinations is 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. Whilst some of this may be due to the age profile of our population, there may be 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 these are more common among particular groups. For example, at Whipps Cross Hospital, DNAs are highest among people living in deprived areas and among 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

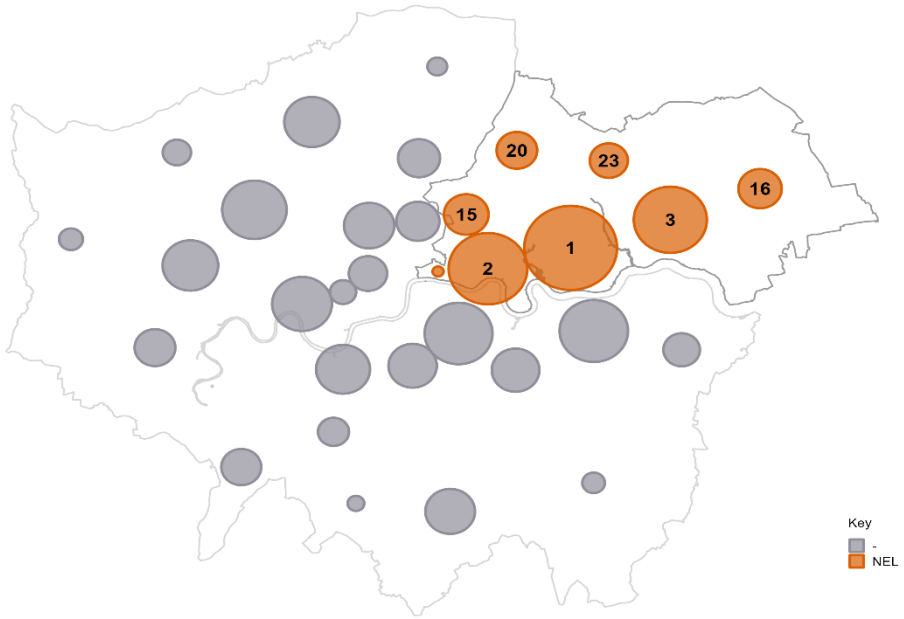
The population of north east London (currently just over 2 million) is projected to increase by almost 15% (or 300k people) between 2023 and 2040. This is equivalent to adding a whole new borough to the ICS, and is by far the largest population increase in London.

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

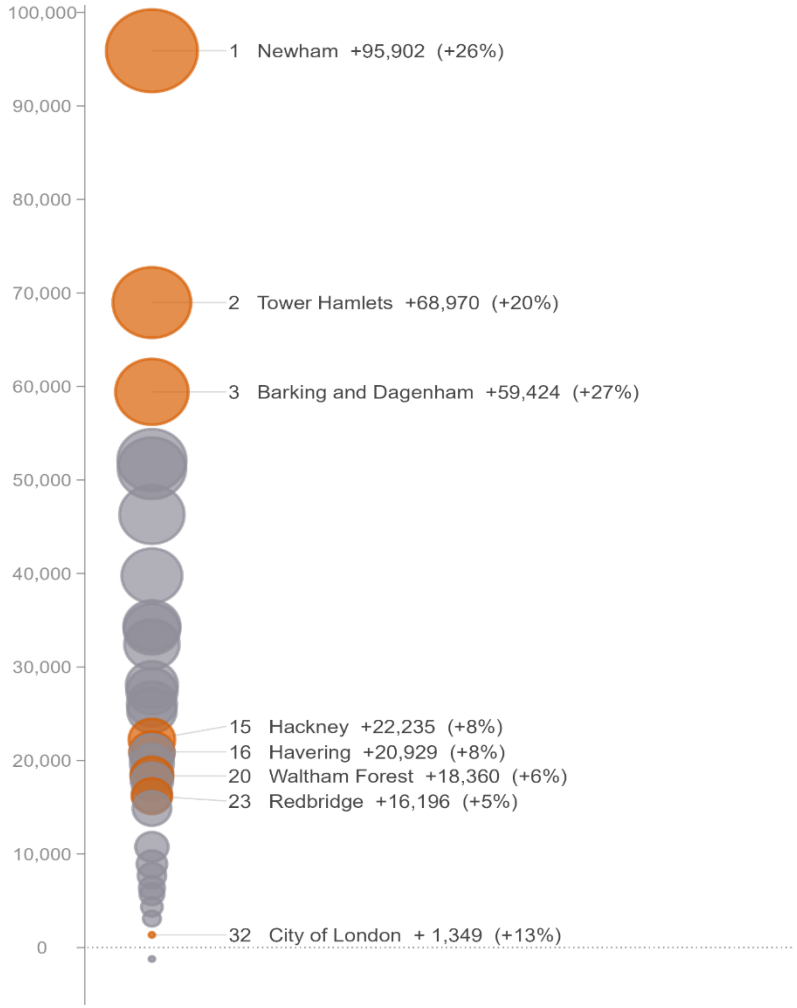
In addition, the age profile of our population is set to change in the coming years. Our population now is relatively young, however, some of our boroughs will see high increases in the number of older people as well as increasing complexity in overall health and care needs.

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



GLA Identified Capacity Scenario, published September 2021, 2020 based

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



GLA Identified Capacity Scenario, published September 2021, 2020 based

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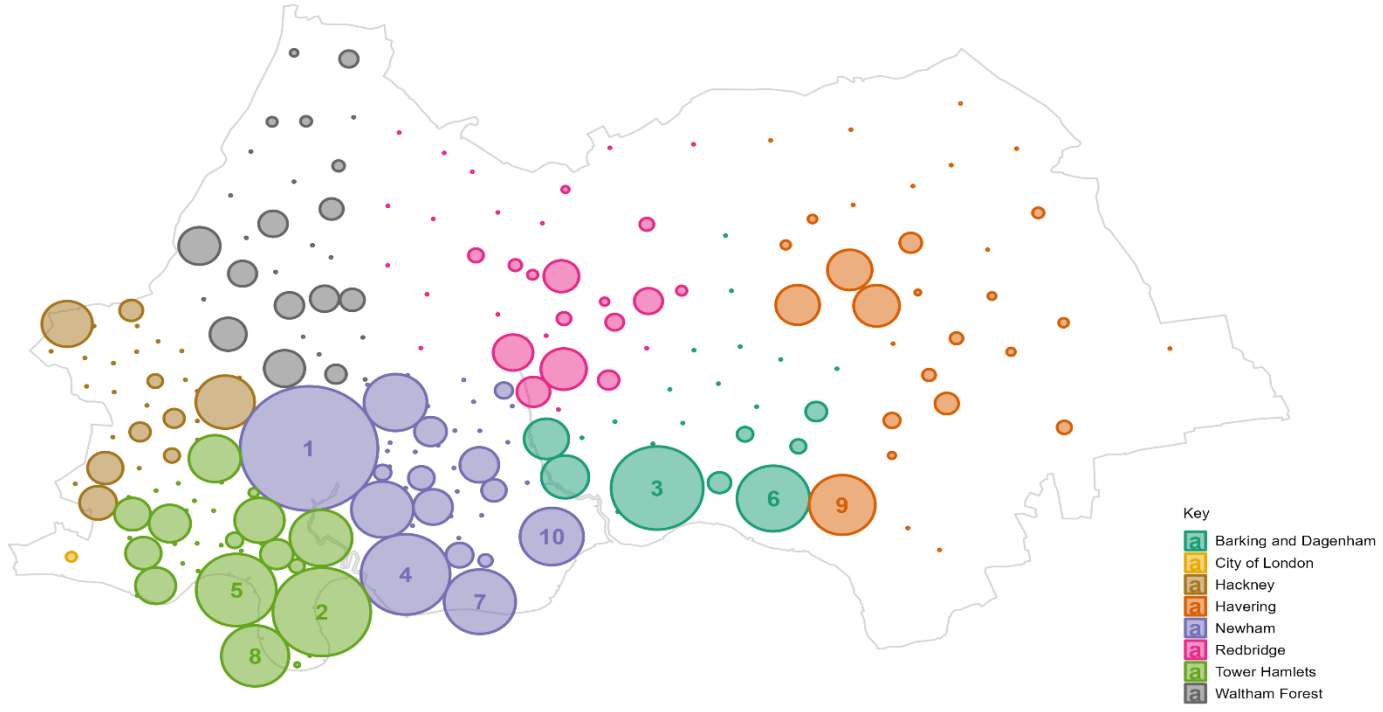
We need to act urgently to improve population health and address the impact of population growth

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 and Dagenham.

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

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

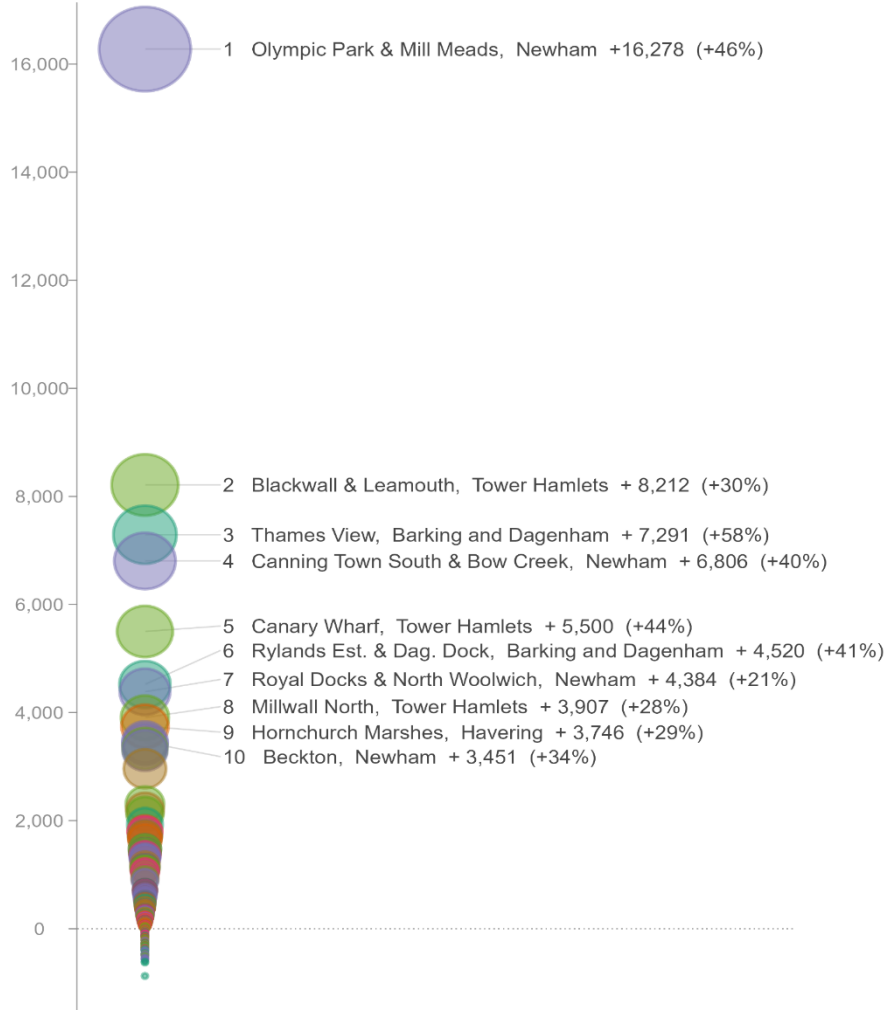
Smallest circles = MSOAs with zero increase or marginal decrease, labelled circles = top 10 NEL neighbourhoods by population increase (1=highest)



GLA Identified Capacity Scenario, published September 2021, 2020 based

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

Labelled circles = top 10 NEL neighbourhoods by population increase



3. Our assets

We have significant assets to draw on

North east London (NEL) has a growing population of over two 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. There are also plans for the Whipps Cross Hospital redevelopment and 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** – 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, and our work with higher education and academia partners, to evidence what works for our diverse communities/groups. We want to build on this 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, and innovate, using data and evidence in order to continually improve. Strong clinical leadership is essential to lead communities, to 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 local people 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. Across our public sector partners in north east London, including local authorities, schools and the police, there is 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 which improve outcomes and reduce inequality in a 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 people.

Our health and care workforce is our greatest asset

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 staff 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. By working in multi-disciplinary teams, the needs of local people, not the way organisations work, will be key. Where necessary, our workforce will step 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 are representative of our local communities at all levels in 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, and to adapt to new ways of working, and, potentially, new roles. AI and digitalisation will play a major role in determining our workforce needs over the next ten years.

Our ICS People and Culture Strategy will ensure there is a system wide plan to underpin the delivery of our new Integrated Care Strategy and Joint Forward Plan, through adopting a joined up 'One Workforce for NEL Health and Social Care' across the system that will work in new ways, across organisational boundaries and be seamlessly deployed for the delivery of health and care priorities. The strategy will focus on increasing support for our current and potential workforce through the implementation of inclusive retention and health and well-being strategies, and creating innovative, flexible and redesigned heath and care careers.

It will ensure right enablers at System, Place, Neighbourhood and in our provider collaboratives, to strengthen the behaviours and values that support greater integration, and collaboration across teams, organisations and sectors. It will contribute to the social and economic development of our local population through upskilling and employing under-represented groups from our local people, through creating innovative new roles, values-based recruitment and locally-tailored, inclusive supply and attraction strategies in collaboration with education providers.

There are almost one hundred thousand people working in health and care in NEL, and our employed workforce is growing every year.

Our workforce includes:

- Over 5,600 people working in general practice (Aug 23)
- 47,638 people working in our Trusts (Aug 23)
- 46,000 people working in adult social care including the independent sector (22/23)
- These are supported by a voluntary sector workforce roughly estimated at over 30,000

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 to supporting a greater shift towards prevention and self-care. They work closely with local communities and are key system transformation, innovation and integration partners.

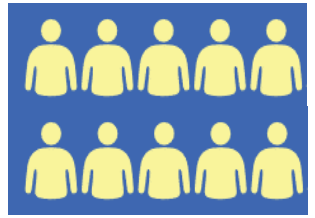
In NEL we are supporting the development of a VCSE Collaborative to create the enabling infrastructure and support sustainability of our rich and diverse VCSE in NEL, also ensuring that the contribution of the VCSE is valued equally.

Social care 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 promotes people's wellbeing and supports them to live independently, staying well and safe, and it includes 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 and 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. As described above, these are significant challenges in north east London, critical to 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 face 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 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 have knock-on impacts.

The wider determinants of health are also key challenges that contribute to challenges. Most of our places we have seen unemployment rise during the pandemic, although this number is dropping, and we still have populations who remain 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. This is 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. 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 4 hour A&E target) • Growing demand for unplanned care within acute settings risks undermining efforts to reduce backlog 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 (4,440 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 by 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 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 fewer GP appointments per 100,000 weighted population than other ICSs in England. 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.
- Across NEL there is wide variation in the number of delivered appointments or average clinical care encounters per week. For 2022/23 this ranges from 93.56 per 1000 (weighted registered) patients in Tower Hamlets, to 68.01 per 1000 (weighted registered) patients in Havering. The NEL average is 77.78 per 1000 (weighted registered) patients.**
- Between March 2022 and March 2023, booked general practice appointments across NEL increased by around 32% to 11 million appointments. 56% of appointments were delivered by other professionals such as nurses and 43% of all appointments were seen on the same day as they were booked*. This figure includes both planned and reactive care. 57% of appointments were patient-initiated contacts, booked and seen on the same day.***
- We are developing a set of principles to streamline patient access to the most appropriate type of appointment and advice, with clear signposting, for health care professionals and local people to ensure they are directed to the full range of services available at Practice and Place, in and out of general practice hours.
- Without substantial increases in primary care staffing the GP to patient ratio will worsen as demand for primary care increases in line with projected population growth. There are pockets of workforce shortages with significant variation in approaches to training, education and recruitment. We are committed to focusing upon retention initiatives such as mentoring and portfolio careers having developed SPIN (specialised Portfolio innovation) which is the basis for the national fellowship programme which we are offering to GPs and other professional groups.
- 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.

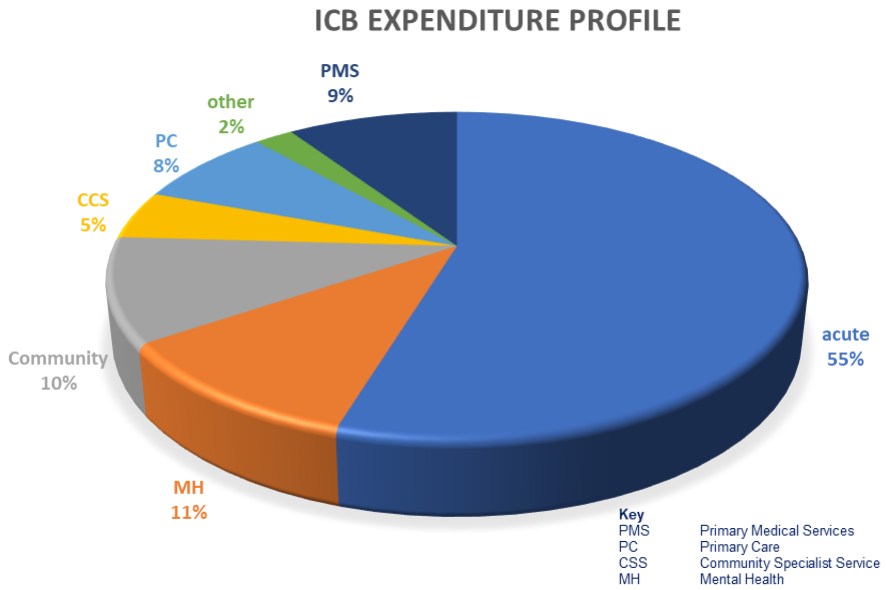
Long term conditions

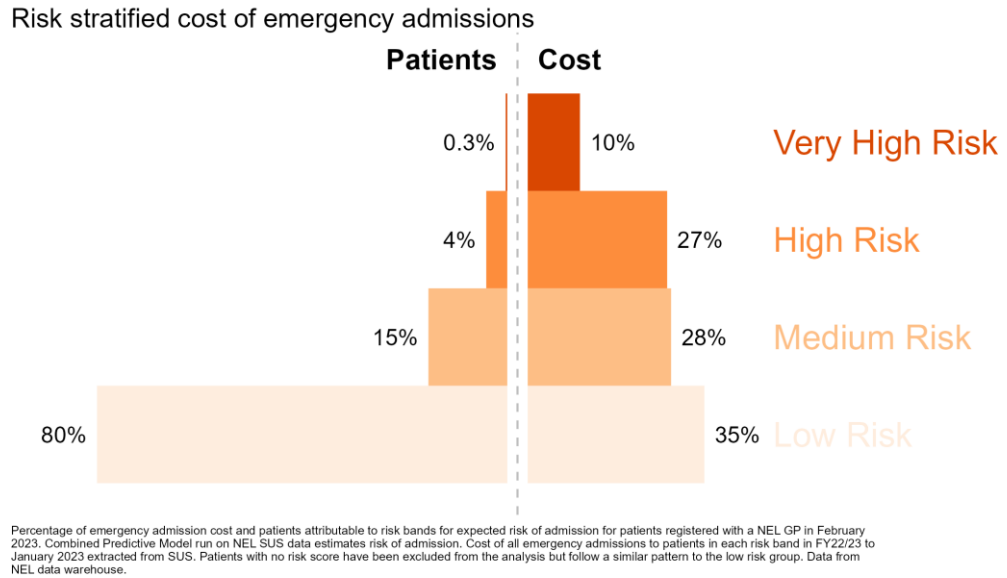
- Across north east London, one in four (over 600 thousand people) have at least one long term condition, with significant variation between our places (in Havering the figure is 33%, vs 23% in Newham and Tower Hamlets).
- Age and deprivation are strong predictors of long term conditions, so while north 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.

 Source(s): *GPAD, **Discovery, ***Edenbridge APEX DRAFT

We need to move away from the current blend of care provision which 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.
- The system has therefore developed a financial recovery plan, which if delivered would result in a £31m deficit in 23/24.
- 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. The system is also looking at a range of further measures designed to improve the underlying run rate.
- In addition to a financial gap for the system overall, there are 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 in 23/24 of £95m, 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. In 24/25 the estimated budget is £86m.
- There is huge variation in the public health grant received by each of NEL's local authorities from central government. 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. This 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 by 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

We are making progress – Our successes

PLACE

HOLDER

SLIDE

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5. How we are transforming the way we work

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 a 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 five 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. Place based Partnerships priorities x7
5. Our cross-cutting programmes

Urgent and emergency care

Portfolio vision, mission and key drivers:
The aim of our portfolio is to improve access to urgent and emergency care for local people that meets their needs and is aligned with the UEC national plan. The portfolio is structured around five strategic system goals: **Prevention** of conditions, **Management** of existing conditions and needs, **Timely intervention** for escalation of needs or new needs and conditions, **Timely and effective return** to community setting following escalation, underpinned by **data, governance, effective pathways and enablers.**
The national and local drivers focus on **increasing capacity**, **growing the workforce**, **speeding up discharge** from hospitals**, expanding new services in the community** and helping people access the **right care first time**.

Key stakeholders:
Place, PCNs, practices, pharmacy, Acute, Community and mental health collaboratives and Urgent and emergency care services. Healthwatch and patient groups.

Key programmes of work that will deliver the vision and mission
The work within the portfolio is mapped against our strategy goals and four outcomes. **1) strengthening provision and access to alternative pathways, 2) optimising flow through hospitals, 3) using population health management to keep people well in the community and 4) setting up governance and pathways to form system wide sustainable plans**.
There are a range of projects to deliver on these outcomes that have been divided into directly managed by UEC portfolio and those sitting in other portfolios.
UEC directly managed – 111 procurement and development, hospital flow, ambulance flow, system co-ordination centre, urgent treatment centres, virtual wards and winter planning.
Other delivery areas such as same day access, urgent community response, mental health pathways and planned care sit in other portfolios but will be monitored and reported to the UEC Board.
Additionally establishing the NEL UEC PMO and governance will provide infrastructure to deliver a measurable impact.

Details of engagement with places, collaboratives and other ICB portfolios
One to ones throughout the summer to understand local strategies and plans to build up the NEL UEC portfolio. Work underway to propose new ways of working and governance structures. Collaboration will be at the heart of the portfolio.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

April 2025:
- System co-ordination centre set up in line with specification
- Reduction in delayed discharges and improvements to A&E performance
- Elimination of ambulance handover waits over 45 minutes
- 111 provider working to a new specification following procurement process
- Expansion and coordination of virtual wards beds

April 2026:
-

April 2027:
-

Engagement with the public:
Engagement activities have taken plan at Place and Trust level which has informed plans and communications – to date there have been NEL UEC patient engagement activities

Community Health Services

Portfolio vision, mission and key drivers:

- Develop a consistent community services offer across NEL
- Improving population health and outcomes, working closely with residents
- Supporting neighbourhoods and PLACEs to enable people to stay well and independent, for as long as possible, wherever they call home
- Creating wider system value by unlocking system productivity gains
- Using evidence to understand the totality of services, outcomes and resources across NEL, identifying opportunities for improved outcomes
- Create and facilitate collaborative partnerships with local authorities, primary care, health providers, and the independent voluntary and charitable sector
- Supporting wider system pressures by maximising CHS opportunities (i.e LAS call outs, UEC attendances, unplanned care, LA residential care pressures)

Key stakeholders:

- 7 PLACEs
- ELFT
- NELFT
- Homerton
- Barts
- 65 plus bespoke providers

Key programmes of work that will deliver the vision and mission

- Leading joint approach to Planning for the first time across NEL
- Coordinating finance discussions across NEL re pressures, risks and priorities
- Developing and evolving Improvement Networks, bringing together subject matter experts and creating a conducive environment to design best practice pathways and consistent offers across NEL
- BCYP Improvement network 15th November
- Rapid Response and Falls Network TBC January '24
- RR and Falls likely to lead to Improvement Network re Community Nursing/integration opportunities across health and social care workforce
- Discussions re MSK pathway in train with Planned Care colleagues
- Aligning with Digital work , Proactive Care, Universal Care Plan, Fuller
- Maximising opportunities for CHS blueprint/integration via Whipps X (WF and RB), St Georges HWB Hub (Havering) and Porters Ave (LBBD)
- Comprehensive CHS Diagnostic planned (to procure Dec '23) giving a bottom up approach from a PLACE perspective, to gain NEL wide understanding of resource, quality outcomes, user and carer experience, cost, workforce across health, local authorities, primary care, VCS

Details of engagement undertaken with places, collaboratives and other ICB portfolios

- Joint planning sessions 1st Nov and 11th Dec (45+ people across PLACEs and providers)
- 121 discussions with Place Directors, core provider leads
- Engagement across collaboratives and programmes (UEC, LTC, BCYP, Planned Care)
- Joint meeting with Primary Care Collab Dec '23

Co dependencies on other programmes

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Developing Consistent pathways and models for CHS, minimising variances in outcomes and experience
- Maximising opportunities to integrate and avoid duplication

Engagement with the public:

- Patient engagement at an early stage but conversations with Patient experience leads Nov '23 to utilise existing forums
- Well established carer and user infrastructure in BCYP

Primary Care

Portfolio vision, mission and key drivers:
Our vision is for north east London to be a place where you can access consistent high-quality primary care, from a dedicated, motivated and multi-skilled workforce enabling local people to live their healthiest lives
The aim of our portfolio is to deliver on ambitious plans to transform primary care, offering patients with diverse needs a wider choice of personalised, digital-first health services through collaboration with partners across the health and social care and communities. National and local plans place a focus on improving access, prevention, personalisation, tackling inequalities and building trusting environments.
Our local challenges include population growth, deprivation, exacerbating poor physical and mental health and workforce retention and development and a financial challenge urging cost effectiveness and efficiency

Key stakeholders:
Place, PCNs, practices, pharmacy, Acute, Community and mental health collaboratives and Urgent and emergency care services. Healthwatch and patient groups.

Key programmes of work that will deliver the vision and mission
There are a range of programme that make up the primary care portfolio to ensure the delivery of our goals.
Empowering patients - supporting patients to manage own health, stay healthy and access services. Improving access - providing a range of services and assistance to respond to patient needs in a timely manner. Modernising primary care - developing new and digital tools to support highly responsive quality care. Building the workforce - staff recruitment, retainment and develop plans in place to improve job satisfaction and flexibility. Working smarter - reduced workload across primary/secondary services and improvements to sustainable and efficient ways of working. Optimising enablers - estate, workforce and communication plans to support the implementation of our goals.

Integrated Neighbourhood Teams (INT) are pivotal to transforming Primary Care and will be delivered through work responding to the Fuller recommendations. **A framework** will offer a streamlined approach for the delivery by integrating Primary Care, including Pharmacy, Optometry and Dentistry, alongside wider health care, social care and voluntary sector organisations. INTs will facilitate care, through 'teams of teams' approach enabling **continuity of care**. These teams will also be instrumental in broadening the availability of care, providing **extended in and out-of-hours services,** including urgent care. A **single point of contact through advanced cloud-based telephony systems** will streamline access to care, while **improved signage and navigation** will guide patients to the right services.

The Fuller initiatives are accompanied by other enabling programmes. **People**, will bolster the **capacity of the ARRS roles**, **establish training and development opportunities**, and **determine the ideal workforce** for INTs. Infrastructure, including, Estates and Data will align current plans to INT requirements, as well as **Digital First** which aims to improve digital access (including remote consultation), NHS App usage, improving practice efficiency and increasing competence to use digital tools.

Wider programmes which are fully or partly delivered through primary care providers, include, **Pharmacy,** enhancing the role of the community pharmacy to improve access and patient self-management, **Long Term Conditions (LTCs),** including a range of interventions such as case-finding, annual or post-exacerbation reviews for targeted patients, as well as programmes that sit in other collaboratives such as **Personalisation** and **Vaccinations**. Other transformational projects to improve dental and optometry services will be developed in the future as their provider groups mature.

Details of engagement undertaken with places, collaboratives and other ICB portfolios
A number on workshops with collaboratives, places and the UEC/ LTC / digital / workforce programmes.
The portfolio is overseen by a lead for UEC portfolio to strengthen interplay. Working in conjunction with other portfolios is a key improvement area following the deep dive in October
Webinars held for PCNs to promote digital tools

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

April 2025:
- Same day handling of all calls to practices
- All practices transferred to cloud based telephony
- Improvements to NHS app and practices websites and e-Hubs
- All practices offering core and enhanced care for people with LTCs
- Additional services from community pharmacies
- All Places have INTs established for at least one patient cohort

April 2026:
- All practices will be CQC rated as GOOD or have action plans to achieve this further equalisation of enhanced services (IN DEVELOPMENT)

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

Engagement with the public: Enhanced access engagement exercise with practices in 2022. London wide digital tools engagement involved NEL residents. Fuller programme plans to engage on the SDA vision

Planned Care

Portfolio vision, mission and key drivers:

- The aim of the programme is to reduce waiting times for elective care in line with the national recovery plan so that no one is waiting more than 52 weeks by March 2025
- This will be delivered through an integrated system approach to improving equity of access to planned care for the people of North East London by focusing on 3 primary drivers – managing demand, optimising capacity & creating new capacity.
- The portfolio of planned care recovery & transformation work spans the elective care pathway from pre-referral to treatment encompassing out of hospital services, outpatients, diagnostics and surgery.
- The planned care portfolio consists of three significant programmes of work – outpatient & out of hospital transformation; diagnostic recovery & transformation and surgical optimisation. The activities and interventions undertaken with these programmes are designed to improve the management of demand, optimise existing capacity and support and enable the creation of new capacity

Key stakeholders:

- Trusts
- APC
- ICB
- Place Based Partnerships
- Primary Care Collaborative including PCNs
- Community Care Collaborative
- Independent Sector Providers – acute and community
- Clinical and operational teams across all acute Trusts

Key programmes of work that will deliver the vision and mission

The portfolio of planned care recovery & transformation work spans the elective care pathway from pre-referral to treatment encompassing;

- **Outpatients and out of hospital services** - The aim of this programme is to optimise the use of our existing outpatient capacity whilst transforming how we work together across primary, community and secondary care to manage demand for services and create a sustainable outpatient & out of hospital system. Achieving this requires transformation across the whole pathway, as well as the way in which outpatient clinics are organised and delivered
- **Diagnostics -** The recovery and transformation of diagnostics includes a broad portfolio of work encompassing imaging, endoscopy, pathology and physiological measurement. The aim of the programme is to create resilient diagnostic services to support elective, including cancer, pathways
- **Surgical Optimisation** - The focus of this programme is to ensure we are using our available elective surgical capacity to increase volumes of activity and reduce waiting times. This includes Trusts improving the utilisation of their elective theatre capacity and optimising the use of NHS and ISP capacity to reduce waiting times. NEL has secured @ £33m investment from the target investment fund to open new theatres in Hackney, Newham and Redbridge, which are expected to operate as system assets.

Details of engagement undertaken with places, collaboratives and other ICB portfolios

The planned care recovery & transformation programme is an integrated system programme with system wide engagement at its heart. Priorities, governance and delivery structures have been created over the last 2 years with primary care, the ICB, PBP and acute providers.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

In NEL, this will mean delivering reduction in waiting times and reducing the variation in access that exists. Key benefits include;

- Reduce variation in service provision and improve equity of access
- Improve referral pathways. Enable patients to get the right service at the right time
- Improve patient accessibility to diagnostics, in order to; reduce pressures on primary and unplanned care, reduce waiting times, reduce steps in patient pathway, reduce follow-up activity; reduce non-admitted PTL, improved utilisation of imaging capacity
- Increase surgical activity at all sites, avoid wasted capacity, enable patients to be offered surgery at sites with shortest wait

Engagement with the public:

The national elective recovery plan has been developed with widespread public engagement. Our programme reflects these priorities, which are adapted to meet the needs of our local population.

Cancer

Portfolio vision, mission and key drivers:

The North-East London Cancer Alliance is part of the North East London Integrated Care System and is committed to **improving cancer outcomes and reducing inequalities for local people.**

Our aim is that everyone has equal access to better cancer services so that we can help to:

- Prevent cancer
- Spot cancer sooner
- Provide the right treatment at the right time
- Support people and families affected by cancer

- **Drivers**
- Our work enables the ICB to achieve its objectives, as set out in the strategy, across the ICB's six cross-cutting themes:
- 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

Key stakeholders:

Patient and Carers
Providers, Partners, PLACE
Cancer board
APC Board and National / Regional Cancer Board

Key programmes of work that will deliver the vision and mission

- The programme consists of projects to improve diagnosis, treatment and personalised care.
- Key milestones to be delivered by March 2025 and 2026 include:
  - Deliver BPTP milestones in suspected prostate, lower GI, skin and breast cancer pathways:
  - Delivering the operational plan agreed for 28d FDS, combined 31d treatment and 62d cancer standards.
  - Deliver 100% population coverage for Non-Specific Symptoms (NSS) pathways.
  - Ensure sustainable commissioning arrangements for NSS pathways are in place for 2024/25
  - TLHCs provided in 3 boroughs with an agreed plan for expansion for all boroughs by 2025.
  - Develop and deliver coproduced quality improvement action plans to improve experience of care.
  - Support the extension of the GRAIL interim implementation pilot into NEL.
  - Ensure all patients are offered the personalised care package with equal access to psychological support, pre-habilitation and rehabilitation services.
  - Personalised stratified pathways can reduce outpatient attendance and allow patients to be monitored remotely reducing the need to attend clinics.
  - Improve the quality of life and support patients need to live beyond cancer.

Details of engagement undertaken with places, collaboratives and other ICB portfolios

- Weekly APG Operational delivery meeting
- Tumour specific Experts Reference Group (ERG)
- Project Delivery Groups (PDG)
- Cancer board – internal assurance
- Programme Executive Board – NEL operational delivery
- APC Board, CAB and National / Regional Cancer Board

Summary of the benefits/impact that North East London local people will experience by April 2025 and April 2027:

2025/26:

- Access to Targeted Lung Health Check service for 40% of the eligible population
- Invitation for up to 45,000 people into the GRAIL pilot
- Continued mainstreaming as part of the Lynch Syndrome pathway
- Improved quality of life and experience of care.

- **2027/ 28:**
  - Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
  - Improved uptake of cancer screening
  - Every person in NEL receives personalised care and support from cancer diagnosis

Engagement with the public:

Patient Reference groups
Campaign workshops

Maternity

Portfolio vision, mission and key drivers:

- Three year delivery plan for maternity and neonatal services: 2023-2026. . This has consolidated 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. The expectations on Local Maternity and Neonatal Systems are that they focus on the following areas;
  - Listening to, and working with, women and families with compassion
  - Growing, retaining, and supporting our workforce
  - Developing a Culture of safety, learning and support
  - Standards and structures that underpin safer, more personalised and more equitable care

Key stakeholders:

All LMNS and APC board Stakeholders (PBC, LA, Trusts, MNVPs- service users, Third sector organisations) Regional Maternity Transformation Team, Chief Midwife Office, ICB BCYP, Public Health.

Key programmes of work that will deliver the vision and mission

- Pelvic Health Service: All women experiencing urinary incontinence to be able to access postnatal physiotherapy up to 1 year post delivery
- Increased breastfeeding rates, especially amongst babies born to women from black and minority ethnic groups or those living in the most deprived areas.
- Midwifery Continuity Care, prioritising the provision to women from Black and minority ethnic (BAME) groups who will benefit from enhanced models of care.
- Perinatal Optimisation Programme:
- Develop pathways to manage abnormally invasive placenta across NEL
- Workforce and Development Projects

Details of engagement undertaken with places, collaboratives and other ICB portfolios

All LMNS and APC board Stakeholders (PBC, LA, Trusts, MNVPs- service users, Third sector organisations) Regional Maternity Transformation Team, Chief Midwife Office, ICB BCYP, Public Health.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- By reducing stillbirth, maternal mortality, neonatal mortality, and serious brain injury in women and babies from BAME groups and women from deprived areas. National ambition to reduce by 50% by 2025
- By closely aligning maternity and neonatal care to deliver the best outcomes for women and their babies who need specialised care by achieving <27 weeks IUT.
- By improving personalised care for women with heightened risk of pre-term birth, including for younger mothers and those from BAME groups and deprived backgrounds
- By ensuring that all providers have full baby-friendly accreditation and that support is available to those who are from BAME groups and/or living in deprived areas who wish to breastfeed their babies
- Ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful and put service user voices at the heart of service improvement. This includes funding MNVP workplans and providing appropriate training, and administrative and IT support.

Engagement with the public:
MNVPs, Third Sector organisations and communities identified in the E&E LMNS report.

Babies, children and young people

Portfolio vision, mission and key drivers:

Vision: To provide the best start in life for the babies, children and young people of North East London.

Mission: The BCYP Programme aims to reduce unwarranted variation and inequality in health and care outcomes, increase access to services and improve the experience of babies, children, young people, families and carers and strengthen system resilience.

Through strong working relationships across health and social care partners, we will increase collaboration, enhance partnership working and innovation, share best clinical and professional practices with each other and deliver high quality services.

Drivers: NEL Integrated Care Strategy, NHS Priorities and Operational Planning Guidance, NHS Long Term Plan, Ongoing impact of COVID-19 pandemic, Royal College of Paediatrics and Child Health – State of Child Health, Academy of Medical Royal Colleges – Prevention is better than cure and NHS England (London Region) Children and Young People's mandated requirements.

Key stakeholders:

ICB Executive, BCYP SRO, Place Directors; Collaborative/ Programme Directors; Provider Directors; GP CYP Clinical Leads;
Directors of Children's Social Care; Designated Clinical/Medical Officers; NHSE (London) CYP Team; North Thames Paediatric Network; Safeguarding Team; Parent Forums

Key programmes of work that will deliver the vision and mission

Acute care - priorities are CYP elective care recovery, diabetes, allergy and addressing urgent and emergency care priorities for BCYP.
Community-based care -priorities are local integrated care child health pilots, increasing capacity (including 7 day access to children's community nursing and hospital@home), improving children's community service waiting times;
National/regional mandated priorities including long term conditions;
Primary care – priorities are BCYP unregistered with a GP, YP access to integrated health hubs; 'You're Welcome standards and Child Health training curriculum;
Special Education Needs and Disabilities (SEND) - SEND Inspection Readiness Group to ensure Places and ICB are prepared for new Ofsted Inspection framework and are meeting NHSE requirements. Focus Areas – Autism and Diagnostic pathways and Pre and Post offers of support for families.
Special cohorts including Child Sexual Abuse (CSA) hub, looked after children and care experienced young people.

Details of engagement undertaken with places, collaboratives and other ICB portfolios

Acute, community, mental health/learning disabilities and autism and primary care collaboratives. LTC and UEC Programmes. Places via NEL BCYP Delivery Group

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

Care is delivered closer to home as our children, young people, their families and carers have requested;
Enhanced quality of care for BCYP with asthma, diabetes and epilepsy;
Improved access to primary and integrated care for BCYP via integrated health hubs;
CYP with SEND will receive integrated support across education, health and care and reduced waiting times for SLT and autism;
Prescription poverty for our care leavers will be tackled.
Reduce the impact of child sexual abuse through improved prevention and better response.

Engagement with the public:

Via Providers.
SEND Parent's Forum
National Voices

Long Term Conditions

Portfolio vision, mission and key drivers:

Our vision - 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, and support communities to prevent LTC onset or progression

Mission - Listening to communities to understand how we can support patients in managing their own conditions

- Reduce working in silos and embed a holistic approach to LTCs
- Reduce unwarranted variation and inequality in health and care outcomes
- Increase access to services and improve the experience
- Working partners to prevent residents from developing more than one LTC through early identification of risk factors
- To ensure there are appropriate interventions and services that support a patient in preventing or managing an exacerbation of their condition
- Keep hospital stay short and only when needed
- To ensure we effectively plan and provide services that are value for money

Key drivers –

Long-term conditions have a national and regional focus as a core component of the Long Term Plan, with attention on Cardiovascular disease, stroke, diabetes, and respiratory. Furthermore, LTCs are entwined with us to address inequalities, and we support projects such as Core25Plus and Innovation for Healthcare Inequalities Programme

Long-term conditions (LTCs) is 1 of NEL's 4 System Priorities for improving quality and outcomes and tackling health inequalities. This is reflected in Place-based priorities which all have identified one or more LTCs

- Across NEL, 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)
- NEL is the highest performing ICB in England for many outcomes related to CVD, stroke, and renal, but local social demographics put the system at risk of continued growth in demand
- Nationally, long-term conditions account for half of GP appointments, 64 percent of all outpatient appointments, and over 70 percent of all inpatient bed days.
- The most deprived areas, people acquired three or more conditions (complex multimorbidity) when they were 7 years younger, compared with the least deprived.

Key stakeholders:

- Residents and communities
- Place based teams
- Regional and National colleagues
- Organisation Delivery Networks
- Voluntary organisations
- Specialised Services
- Pharmacy and Medicine Optimisation
- Primary care
- Babies, Children and Young People
- Communities services
- Community collaborative
- Planned care
- Acute Provider Collaborative
- Mental health programme and collaborative
- Urgent Care programme
- BI and insights
- Communication and engagement
- Contracting and finance

Key programmes of work that will deliver the vision and mission

Primary LTC prevention & Early identification

Social determinants of health (SDOH) impact 80% of health outcomes from chronic disorders and across NEL we have areas of significant deprivation which is linked with increased prevalence of long-term health conditions and lower life expectancy

We want to work with our local population to empowering and enabling people to manage their own health and engage in healthy behaviours across their lives, so they don't develop a LTC.

Secondary prevention and avoiding complication

DH data has demonstrated that **9 out of 10 strokes** could be prevented and u**p to 80% of premature CVD deaths are preventable**, if risk factors could be controlled. Working with social communities, and ensuring we provided person focused early identification, secondary care and avoiding complication enables us to improve outcome and reduce exacerbation of an LTC

Co-ordinated care and equability of service

Across NEL, **one in four (over 600 thousand people) have at least one long-term condition**, with significant variation between our places. The feedback from the Big Conversation reflects the need to join-up care and move forwards person focused approach. Working with colleagues at place we aim to continue to review current provision and reduce unwarranted variation in care across the pathway, with an aim of improving health outcomes

Enabling people to live well with a LTC and tertiary prevention

The effective support and management of LTC will increasingly require the management of complexity, and moving away from a single condition approach. In NEL 3 in 5 patients with a diagnosed long term condition have only one condition, the other **2 in 5 have multiple co-morbidities, of which diabetes and hypertension were most common**

Details of engagement undertaken with places, collaboratives and other ICB portfolios

Places – working with Heads of Live well across the 7 places who are responsible for LTCs

Clinical/improvement Networks – wider engagement with trusts, community providers, pharmacy, primary care and place

Organisation Delivery Networks (renal and CVD/cardiology)

Other programme directors including specialised service, community, mental health, BYCP.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

Work toward national targets including:

- 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 access to and uptake of Cardiac Rehabilitation (CR) – by 2029 85% of eligible patients are accessing CR
- 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).
- nting 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

Engagement with the public:

The big conversation which consists of 56 focus groups, 430 attendees of key community events and local survey focused on LTCs and the outputs are incorporated into priorisation for 24/25.

Furthermore, we have incorporated feedback at service level such PR and diabetes

Mental Health

Portfolio vision, mission and key drivers: the aim of the Mental Health, Learning Disability and Autism Collaborative is to work together to improve outcomes, quality, value and equity for people with, or at risk of, mental health problems and/or learning disability and autism in North East London. We do this by putting what matters to service users and their families front and centre of everything we do.

The service user and carer priorities that represent our key drivers include:

- Improving peoples' experience of accessing mental health services, including their first contact with services, and ensuring equity of access
- Children and young people can access different support from different people, including those with lived experience, when and where they need it
- People with a learning disability have the support they need and a good experience of care, no matter where they live

Key stakeholders: NHS North East London, East London NHS Foundation Trust, North East London NHS Foundation Trust, local authorities, primary care, voluntary, community and social enterprise sector organisations, service users, carers & residents

Key programmes of work that will deliver the vision and mission

1. Investing in and developing lived experience leadership across the MHLDA Collaborative so that experts by experience are active and equal partners in leading improvement and innovation across mental health, learning disability and neuro-developmental services
2. Continuing the work led by our children and young peoples' mental health improvement network to reduce unwarranted variation across boroughs, and to do more of what works to reduce self-harm and improve outcomes for young people
3. Accelerate the work of our talking therapies improvement network to improve access, and continue to transform and improve community mental health services, with a particular focus on improving equity of access for minoritised groups and people with neurodevelopmental needs
4. Continue our focus on improving mental health crisis services and alternatives to admission - while also working to ensure that quality inpatient services are available for those who need them - making sure that people get the right support, at the right time, and in the right place
5. Working to develop core standards for community learning disability services, with a view to reducing unwarranted variation between boroughs, and sharing good practice to support our specialist workforce better

Details of engagement undertaken with places, collaboratives and other ICB portfolios: Place based priorities for mental health are the cornerstone of our plans. We also connect closely with the Acute Provider Collaborative on mental health support in emergency departments and form part of their programme governance on UEC. We also have strong links into the BCYP programme and community health.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Improved access, outcomes and experience of NHS Talking Therapies for minoritised communities and other under-served populations
- Improved system-wide response to children and young people presenting with self-harm through the introduction of new evidence-based interventions, including better support to teachers, GPs and parents
- Improved offer of pre-diagnostic, diagnostic and post-diagnostic support for people with neurodevelopmental support needs
- Greater equity in the community learning disability support offer across boroughs
- Improved inpatient services with lower lengths of stay, and better options of high-quality supported housing / residential care for those who need it
- Widespread adoption of personalised and person-centred care planning processes with an emphasis on continuity of care and biopsychosocial assessment

Engagement with the public: Our Lived Experience Leadership arrangements ensure we are continually engaging with children and young people, adults with mental health needs and people with learning disabilities and their families, and coproducing our work with service users

Employment and workforce

Portfolio vision, mission and key drivers:
- Our vision is to create a transformational and flexible “One Workforce for NEL Health and Social Care” that reflects the diverse NEL communities and meets our system priorities.
- The mission focuses on developing a sustainable and motivated workforce, equipped with the right skills, competencies, and values, to improve the overall socio-economic outcomes of our NEL populations.
- The key drivers are responding to population growth and increasing demand, and developing meaningful and rewarding careers within health and social care services for local residents.

Key stakeholders:
- Provider CPOs
- People Board
- Place Directors
- Staff
- Local Authorities
- Care Sector

Key programmes of work that will deliver the vision and mission
- **System Workforce Productivity:** Continuing to address NEL’s difficult financial position through urgent investigation of workforce productivity drivers and implementation of productivity improvement initiatives.
- **System Strategic Workforce Planning:** Development of a strategic workforce planning function with the capacity, capability and digital enablers to provide the enable evidence-based decisions to ensure the long-term sustainability of the NEL Health and Social Care workforce. With the ultimate aim of developing of a system-wide health and social care workforce database and an integrated workforce planning system.
- **System Anti Racist Programme:** Embedding inclusive, anti-racist and empowering cultures across the system.
- **System wide scaling up and corporate services:** Identification of corporate services with scope for rationalisation. Streamlining operations, improving efficiency, standardising approach and reducing costs.
- **NEL Health Hub Project Programme:** Connecting local health and social care employers with colleges for employment opportunities. . Healthcare part is in partnership with Newham College and London Ambulance service and funded by GLA until March 2024. Social Care part is led by Care Provider Voice, aiming for 150 job outcomes, and funded until March 2025.
- These programmes are subject to approval by the People Board, Exec Committee, CPOS, Place, and collaboratives, aligning with the goal of enhancing socio-economic status in NEL through workforce development.

Details of engagement undertaken with places, collaboratives and other ICB portfolios
- Engaged with a broad spectrum of Health and Social Care partners through workshops and sessions.
- Involved Local Authorities, Voluntary and independent Care Sectors, Primary Care, NHS Trusts, Provider collaboratives, and Education Providers.
- More engagement is required.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- **Integrated Health and Social Care Services:** Enhanced workforce development will lead to more integrated and effective health and social care services, improving overall care delivery.
- **Workforce Expansion and Skilling:** Initiatives like the NEL Health Hub and Social Care Hub are set to expand the healthcare workforce, providing training and development opportunities, leading to better staffed and skilled services.
- **Healthcare System Sustainability:** Focus on financial stewardship and innovation will contribute to a more sustainable healthcare system, ensuring long-term service delivery and effectiveness.
- **Equity in Healthcare Employment:** Targeted employment opportunities for under-represented groups in health and social care sectors will enhance workforce diversity, contributing to more inclusive and equitable healthcare services.
- **Enhanced Health and Well-being Services:** Programs like the Keeping Well Nel programme, funded until June 2024, will enhance health and well-being services, directly benefiting the ICS, workforce, and indirectly impacting local population health.

Engagement with the public:
- Actively engaged ICS staff via hackathons and NEL residents through community events and job fairs.
- Utilized feedback from the Big Conversation for inclusive strategy development.
- More engagement is required.

Specialist Commissioning

Portfolio vision, mission and key drivers:

Our vision:

- is to ensure that the population of north east London have good access to high quality specialist care that wraps around the individual, and ensures the best possible outcomes

Our mission and drivers:

- We are responsible for planning and commissioning of delegated specialised health services across north east London. We are responsible for specialised spend, performance and outcomes, and ensuring all parts of the local health system work effectively together to deliver exemplary specialist care
- We are responsible for integrating pathways of care from early intervention and prevention of LTC through to specialist provision, ensuring end to end pathways to improve outcomes and manage future demand of costly specialist care.
- We set priorities for specialised services and work with our local ICS, multi ICB partners and London regional partners to deliver world class specialised services to benefit patients within north east London, North London or London ensuring access to the right level of care.
- We will do this by working together with health partners, specialist providers, local authorities and the voluntary community and social enterprise (VCSE) sector, with residents, patients and service users to improve how we plan and deliver specialised services.

Key programmes of work that will deliver the vision and mission

From 2024/25, ICBs will have budget allocated to them on a population basis, and from April 25 this will be allocated on a needs based allocation basis. The specialised allocation will follow a similar formula to that of other nonspecialised services that ICBs hold, and **so can be considered and contracted for alongside the rest of the pathways we commission**. Delegation of specialised services and transformation of specialised services allows us to consider the totality of resources for our population, making it easier to ensure investment in the most optimal way to improve quality and outcomes, reduce health inequalities and improve value.

The key programmes of work are to:

1. Ensure safe delegation of specialised services working alongside the NHSE regional team
2. Joint work with NHSE, London ICBS and locally in NEL focussed on specialised transformation: sickle cell disease (Haemoglobinopathies), HIV and Hepatitis (including liver disease), Renal disease, Neurosciences, Cardiology, complex urogynaecology and specialist paediatrics
3. Working alongside other portfolios will deliver this mission, mainly LTC to ensure a whole pathway approach routed in place, cancer, planned care, critical care, BCYP and mental health

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

HIV

- People living with HIV will have improved 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.

Renal

- Working towards maximise patient dialysing at home - 496 patients on home therapies by 31/32 (target of 28% of patients on home therapies by 2032).
- Working towards maximise patients being transplanted - 280 transplant operations completed in 31/32

Sickle Cell

- 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
- 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.

Hepatitis and HIV

- 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%).

Neurosciences

- 10% of eligible stroke admissions will have consistent 24/7 access to mechanical thrombectomy to reduce the impact of stroke
- 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.

Cardiology

- Shorter waiting times and reduced elective and non-elective
- HF 30 day readmission rates have recently risen to more than 20%. We aim to reduce this to reduce this <15% with roll out of dedicated HF pharmacist to review and titrate patients post discharge

Key stakeholders:

- NHS London Region and London ICB partners
- NEL Provider Trusts
- North London ICB Programme Board partners (NCL/NWL)
- ODNs, mandatory and local clinical networks
- EoE Region
- Local authorities
- VCSE

Details of engagement undertaken with places, collaboratives and other ICB portfolios:

- APC Executive
- APC Joint Committee
- NEL Executive leads
- Close working with other ICB portfolios: LTC, Cancer, Planned Care, Critical Care, CYP, mental health

Engagement with the public:

- Engagement via regional and local clinical networks including Renal service users to inform dialysis provision
- Cardiac ODN: women, family
- HIV work with charities

Digital

Portfolio vision, mission and key drivers: There are four key elements to the ICS digital strategy; patient access, population health, shared record access and provision of core infrastructure:

- **Patient Access** gives residents the ability to view their records and interact digitally with health and care providers. This is and will be provided through expanding use of the NHSApp, Online and Video consultation tools, online registration and the patient held record system, Patients Know Best
- **Population Health** utilises a variety of data sources to build a picture of care needs at various levels, primarily identifying specific cohorts of patients requiring intervention but also providing overviews at population level, allowing providers to alter service provision
- **Shared Records** is the mechanism for ensuring that clinicians and other care professionals have as full a picture as possible to allow them to provide the most appropriate care to individual patients / residents. This was pioneered in NEL and is now used across London and beyond
- **Core infrastructure** is the fundamental basis for all digital activity; the foundational work done at each provider that allows them to operate effectively and puts them on a sure footing to be able to contribute to and receive data from systems external to themselves

Key stakeholders:
All ICS health and care providers including NHS trusts, local authorities, GPs, community pharmacists, care home providers, third sector health and care providers, NHS England

Key programmes of work that will deliver the vision and mission
The largest investment currently taking place is the replacement of the core electronic patient record (EPR) system in BHRUT. This is being replaced by extending the existing Oracle Millennium system in use at Barts Health. Planning is underway, with the system expected to be live by March 2025. Other significant investments in Trusts include:

- The expansion of the functionality available via the NHSApp to include the ability to manage hospital and community appointments, and the ability for patients and clinicians to interact digitally where appropriate, thus improving the experience for digitally enabled patients and freeing up resource to support those wishing to use traditional methods. This is enabled by the PHR programme
- Use of artificial intelligence and robotic process automation to support diagnostics and faster completion of administrative tasks such as clinic management within trusts, thus improving patient experience and reducing the administrative burden on trusts
- All acute trusts using the same imaging platform to store and view x-rays, scans, etc., reducing the requirement for repeat diagnostic procedures and making them available to any clinician that needs access. ICS-wide cyber security plans are in place with funding having been secured
- Introduction of remote monitoring equipment to support expansion of virtual wards

Details of engagement undertaken with places, collaboratives and other ICB portfolios
Members of the digital team attend portfolio and collaboratives' meetings. A meeting has taken place with place directors but further meetings are needed.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Residents can choose to interact with health and care professionals via the use of the NHSApp, Patient Held Record, online consultation and video consultation tools, which will smooth their interaction with the NHS and free up capacity to deal with people choosing to use other routes
- Patient level and aggregated information is provided to clinicians, managers and researchers, subject to a strict approval process. This helps change the planning and delivery of healthcare provision
- NEL hosted data is used across London and neighbouring ICS's, breaking down barriers by facilitating the sharing of information and good practice
- Information is provided to individual clinicians and other professionals from within their main system, giving access to information held by most London Trusts, which enables them to provide
- Key strategic programmes are co-ordinated by the ICS team, including Community Diagnostic Centres, Frontline Digitisation, Virtual wards, Care Sector, secondary care Appointment Systems and Primary Care Digital First, working with health, social care and third sector partners

Engagement with the public:
The One London programme has held various consultation meetings with patients across London, the results of which inform the strategies of each of the ICS' across London. Further engagement has been requested through further 'Big Conversations' planned in NEL

Finance

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

- Improving quality and outcomes for local people of north east London
- Securing greater equity for our residents
- Maximising value for money
- Deepening collaboration between partners

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

- Incentivising transformation and innovation in clinical practice and the delivery of services to improve the outcomes of local people
- Supporting delivery of care closer to patients' homes, including investing in programmes that take place outside the hospital environment
- Refocus how the money is spent to focus on population health, including proactive measures that keep people healthier and to level up investment to address historical anomalies of funding
- Increasing investment in prevention, primary care, earlier intervention and the wider determinents of health, including environmental sustainability

Key programme features and milestones:

- Supporting our providers to reduce transactional costs, improve efficiency and reduce waste and duplication
- Support the financial stability of our system providers and underpinning a medium to long term trajectory to financial balance for all partners
- Recognising existing challenges, including that NEL is, as a SOF 3 ICS, financially challenged with a growing population and an acute provider (BHRUT) in SOF 4 for financial performance.
- Ensuring we do not create unnecessary additional financial risk, especially in the acute sector
- ICS investment pool to fund programs designed to reduce acute demand
- Finance development programme to agree overall budgets and develop place based budgets and budgetary delegation to place
- Effective integration of specialised commissioning, community pharmacy, dental and primary care ophthalmology services

Further transformation to be planned in this area:

- Supporting the integration of health and social care for people living with long term conditions who currently receive care from multiple agencies
- Ensuring that all partners are able to understand and influence the total amount of ICB resources being invested in the care of local people.

Programme funding:

- ICB plan submitted with a total budget of £4,218m in 23/24
- Specific transformation budgets, including health inequalities, virtual wards, physical, demand and capacity funding

Leadership and governance arrangements:

- Reporting to the ICB Board and Place Partnership Boards
- Finance, Performance and Investment Committee
- Audit and Risk Committee
- CFO lead monitoring of monthly and forecast performance

Key delivery risks currently being mitigated:

- Risk to delivery of a balanced financial position. Mitigated by delivery of efficiencies, delay of planned investments

Physical infrastructure

Capital pipeline work to be completed Jan. Review in January 2024

The benefits that north east London local people 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 centre on the site of St George's, Hornchurch
- Formal opening of new St George Health and Wellbeing Hub – **Spring 2024**

How this transformation programme reduces inequalities between north east London's local people 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

Barking & Dagenham

Portfolio vision, mission and key drivers:

Vision

By 2028, residents in Barking and Dagenham will have improved physical and mental health and wellbeing, with a reduction in the gap in health inequalities between Barking and Dagenham resident and people living elsewhere. Our strategic aims are to:

- Enable babies, children and young people to get the best start in life
- Ensure that residents live well and when they need help they can access the right support at the right time in a way that works for them
- Enable residents to live healthier for longer and be able to manage their health, have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious

Interdependent ICB programmes

- Babies, Children and Young People; Maternity programme; Fuller programme; Population Health programme; Long Term Conditions programme; Urgent & Emergency Care programme; Estates

Interdependent Collaborative programmes

- Acute; Community Health; Mental Health, Learning Disability and Autism; Primary Care; VCSE

Key programmes of work that will deliver the vision and mission

- **Improving outcomes for CYP with SEND** with a focus on therapy support, ASD diagnosis and pre-and post-diagnostic support, mental health in schools
- **Tackling childhood obesity** leveraging the opportunities through family and community hubs for prevention
- **Development of Integrated Locality Health and Social Care Teams** (physical and mental health)
- **Developing a proactive and prevention approach to delivery of services** with targeted prevention approaches for falls prevention, dementia diagnosis and early support; long-term conditions identification and support and health outcomes for people who are homeless
- **Optimising outcomes and experience for pathways - d**eveloping a 24/7 Community End of Life Care Model; integrated Rehab and Reablement services; high Intensity User Services; demand and capacity management of high risk pathways (waiting list management)
- **Improving the physical health of people with SMI**

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- BCYP get the best start, are healthy, happy and achieve, thrive in inclusive communities, are safe and secure and grow up to be successful young adults
- Providing accessible services and support for residents to prevent the development of health conditions wrapped around local communities
- Improving physical and mental health and wellbeing for residents, particularly those with long term conditions
- Reduced reliance on acute and crisis services
- Improved physical health outcomes for those with a serious mental illness

Key stakeholders:
NELFT
Primary care/PCNS
BHRUT/Barts
VCSE
Healtwatch
Local Authority- childrens and adults services; public health
Estates and housing teams

Engagement with the public:
Best Chance Strategy for CYP and families; Just Say Parent Forum, engagement in Adults and Community strategy (ongoing)

Havering

Havering Place based Partnership vision, mission and key drivers:
A Healthier Havering where everyone is supported to thrive; The vision of the Havering Partnership is to pool our collective resources to create person centred, seamless care and support designed around the needs of local people throughout their life course, with a strong focus on prevention, addressing inequalities and the wider determinants of health. This compliments Havering Council's vision for the 'Havering that you want to be a part of', with a strong focus on people, place and resources. We will do this by; Tackling inequalities and deprivation to reduce the impact that this has to access to services, and outcomes; Improving Mental and Emotional Support, Tackling Havering's biggest killers; Improving earlier care and support; coordinating and joining up care; working with people to build resilient communities and supporting them to live independent, healthy lives.

Interdependent ICB programmes
- Mental Health
- Long Term Conditions
- Urgent and Emergency Care
- Workforce and other enablers such as digital
- Planned Care
- Carers work and other cross place programmes

Interdependent Collaborative programmes
- Acute Provider Collaborative
- Community Provider Collaborative
- VCSE Provider Collaborative
- Mental Health Provider Collaborative
- Primary Care Collaborative
- North East London Cancer Alliance

Key programmes of work that will deliver the vision and mission
- **Start Well**; Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives
- **Live Well**; People enjoy and are able to maintain a sense of wellbeing and good health, supported by resilient communities. They can access care and information when needed.
- **Age Well**; People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks
- **Die Well**; People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people
- **Building community resilience programme and other key enablers**; including improvements to Primary Care and delivery of the recommendations in the Fuller review, roll out of the Joy App as our single database of services and referral mechanism for social prescribing, making better use of our estate and delivery of new models of care such as the St Georges project, improvements to urgent and emergency care, imbedding a prevention approach, addressing our key workforce challenges by working together, creating the enabling framework for place including information sharing agreements between partners to enable decisions and service improvement to be driven by joined up data.
- Built on a foundation of a **joint health and care team**, bringing together the Havering Place NHS team with the Local Authority Joint Commissioning Unit to deliver improved outcomes for local people and better value for money in our commissioned services

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

Start Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Reduce the number of children and their families attending Emergency Departments for non-emergency care	Increase the number of Children and Young People receiving support for their emotional wellbeing through Primary Care	Increase the number of children and their families receiving best practice End of Life Care provision
Reduce the number of Children and Young People attending Emergency Departments in emotional or mental health crisis	Increase the number of children receiving timely Autism Spectrum Disorder (ASD) diagnosis and integrated family support	
Improve access to services and reduce wait times, particularly for Primary Care, non-elective care, and other services	Reduce the wait time of children for Special Educational Needs therapy provision	
Reduce spend on care for those with more complex needs by looking at innovative and local solutions for placements	Increase the use of Child Health Hubs to deliver integrated community care for children and their families	
Deliver greater value for money through joint commissioning of contracts where possible, which will also deliver more seamless, integrated services for local people	Reduce the percentage of children who are physically inactive and/or obese	
	Reduce the number of children and young people living in cold, damp or mouldy homes	

Live Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Improve access to services and reduce wait times, particularly for Primary Care, non-elective care, and other services	Increase diagnosis rates for type 2 diabetes and hypertension	Increase healthy life expectancy
Reduce the percentage of adults who are physically inactive and/or obese	Increase the percentage of adults with a learning disability living in settled accommodation	Reduce the gap in life expectancy between the most and least deprived areas of the borough
Reduce smoking prevalence in adults	Increase the percentage of cancers being diagnosed at an earlier stage	Reduce alcohol-related mortality
Increase the number of social prescribing referrals to support people to access wider wellbeing support	Reduce the number of people living in cold, damp or mouldy homes	Reduce the rate of suicides
Increase the number of people who provide informal and unpaid care who are registered with the Carers Hub and in receipt of information and support		Reduce early deaths from cardiovascular disease and respiratory disease
Increase use of digital enabled systems to support early detection for Atrial Fibrillation and Chronic Kidney Disease		Eliminate all inappropriate out of area mental health placements
Increase uptake of home testing including ACR and blood pressure		
Increase the number of people being referred to the national diabetes prevention programme		
Reduce wait times and increase support for those with lower level mental health issues to enable a preventative approach to mental health and wellbeing		

Age Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Increase the number of older people with a personalised care and support plan	Reduce the number of older people being referred for adult social care	Reduce permanent inappropriate admissions into residential care
Reduce the rate of emergency hospital admissions, including readmissions	Increase access for older people with a common mental illness to psychological therapies	Reduce the percentage of older people reporting that they feel lonely
Reduce the rate of acute length of stay for frail older people, returning them home sooner	Increase the number of volunteers supported to find a volunteering opportunity	
Reduce the rate of older people having discharge delays from hospital (delayed transfers of care)	Reduce the number of frail older people living in cold, damp or mouldy homes	
Increase the number of informal and unpaid Carers having a carer assessment and receiving appropriate support	Increase the number of older people who have their seasonal flu vaccination	

Die Well Ambitions		
Immediate ambitions (1-3 years)	**Medium term (3-5 years)**	**Long term (5 - 10 years)**
Increase the percentage of people who have, or are offered, a personal health budget towards end of life (fast-track)	Increase the percentage of people in the last 3 years of life who are registered on a local end of life register	Increase, in the recording of preferred place of death
Reduce the average number of patients per month who die in hospital whilst being delayed to be discharged	Increase access to Bereavement support in Havering	Increase the number of people who die in their preferred place of death
Reduce the percentage of older people who die within 7 days of an emergency hospital admission	Reduce the percentage of older people who die within 14 days of an emergency hospital admission	

Full details of the benefits are captured in the Havering Place based Partnership interim strategy

Key stakeholders:
- **Local People**
- **Staff**
- **VCSE**
- **London Borough of Havering and their staff, who are coming together with the NHS Place team to form a joint team**
- **NELFT**
- **BHRUT**
- **Healthwatch**
- **Care Providers Voice (including Home Care and Care Home providers)**
- **PELC**
- **Primary Care including the GP Federation and PCNs**
- **NHS North East London partners**
- **Police and other community partners**
- **Wider NHS partners**
- **Wider Community partners and groups**

Local People are at the heart of all of the work of the Place based Partnership

Engagement with the public:
A significant engagement programme has been underway with local people, VCSE groups, and stakeholders since the inception of the partnership. We are building an ongoing relationship with local people, and developing case studies to embed their experiences to drive improvements locally.

Redbridge

Place vision, mission and key drivers:

VISION: The Redbridge Partnership will relentlessly focus on improving the outcomes for the people of Redbridge and seek always to make a positive difference to people's lives. Together, we will build on what we have already achieved and use our combined resources to create person-centred, responsive care to build services around the needs of our communities within Redbridge. We will have a strong focus on prevention, addressing inequalities and the wider determinants of health**.**

KEY PRIORITIES: Babies,Children & Young People (BCYP)-Childhood Immunisations, **Housing & overcrowding, Multi-Disciplinary Team working(MDT)-** service integration, **Mental Health (MH)**– Access & wellbeing

DRIVERS: Good governance and accountability, a focus on the patient/resident's voice, a focus on Organisational Development, Commitment to working in partnership and beyond organisational boundaries, reliable data to inform impacts and adequate resourcing

Interdependent ICB portfolios

Long Term Conditions (LTC), Learning Disabilities (LD)/Mental Health (MH), Planned Care (PC), Health Inequalities (HI), Babies, Children and Young People (BCYP), Urgent and Emergency Care (UEC)

Interdependent Provider Collaboratives

Community Collaborative, Acute Provider Collaborative, Cancer, Collaborative, Primary Care Collaborative, Mental Health Collaborative

Key programmes of work that will deliver the vision and mission. (PLEASE NOTE THE PRIORTIES ARE PLANNED TO BE FORMALLY SIGNED OFF AT THE JANUARY 24 PARTNERSHIP BOARD.)

Start Well: Hospital at Home, Paediatric Integrated Nursing Service (PINs), Learning Disability Key workers, Integrated child health hubs, Special Education Needs & Disability (SEND), Children & Young People Asthma one stop shop

Live Well: Long Term Conditions Prevention/diagnosis, A Cardio renal and cardio vadcular programme, Increase health checks for residents with Serious Mental Illness (SMI) , Mental Health & Learning Disability, Review of Commissioning overlaps between organisations, Improve quality of life for residents of Redbridge.

Urgent & Emergency Care/Ageing Well: Keeping people well at home, Same day access to urgent care, Hospital flow-length of stay in hospital, Discharge from Hospital, End of Life Care, Avoidance of unnecessary attendance and admissions to hospital.

Primary Care: Fuller Programme (Integrated Multi-Disciplinary Care, Staying well for longer, Access to care & advice), Direct Enhanced Services, Local Incentive Schemes, Same Day Access and extended hours care, Asylum Seekers services, Homeless Services, Spirometry

Health Inequalities: Various schemes addressing Core 20+5

Ilford Exchange Health Centre: To develop and deliver a new health centre in Ilford town centre following an extensive public consultation in September 2022. The consultation was over 6 weeks and included a range of engagement tools and events such as public surveys, information stands, 4 public engagement events and 1 event with a local charity One Place East.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

By April 2025 and 2027 the Redbridge Place Based Partnership will:

- Significantly reduce the variation in undiagnosed Long Term Condition diagnosis rates and improve early treatment intervention.
- Significantly improve the uptake of childhood immunisations
- Improve the rate of Healthchecks for residents with Serious Mental Illness.
- Reduce the number of Children & Young People patients attending A&E through the hospital at homes programme
- Significantly reduce health inequalities underpin by the Core20+
- Improve same day access for residents across both health and care
- Have a new integrated health centre operational in the Ilford Exchange by 2025.

Key stakeholders:

- London Borough of Redbridge (LBR)
- Redbridge Community Volunteer Service (RCVS)
- Healthwatch
- Healthbridge (GP Federation),
- The Primary Care Networks (PCNs) in Redbridge
- North East London NHS Foundation Trust (NELFT),
- NHS NEL ICB
- Barking Havering & Redbridge University Hospitals NHS Trust (BHRUT)
- Barts Health NHS Trust (specifically Whipps Cross),
- Provider Collaboratives
- Care Provider Voice CPV)
- PELC
- LMC
- BHR CEPN

Engagement with the public:

The RBP will engage with local communities and organisations to create a strategic priorities programme that is informed by the views of local people. In particular we plan to have engagement workshops once the key priorities are signed off in January 2024, to shape the work programmes.
We will also have resident rep's on each Steering Group which are sub-committees of the Partnership Board.

Tower Hamlets

Portfolio vision, mission and key drivers:

- Tower Hamlets residents, whatever their backgrounds and needs, are supported to self-care, thrive and achieve their health and life goals
- Health and social care services in Tower Hamlets are accessible, high quality, good value and designed around people's needs, across physical and mental health and throughout primary, secondary and social care
- Service users, carers and residents and children are active and equal partners in health and care and equipped to work collaboratively with THT partners to plan, deliver and strengthen local services
- All residents - no matter their ethnicity, religion, gender, age, sexuality, disability or health needs - experience equitable access to and experience of services, and are supported to achieve positive health outcomes

Interdependent ICB programmes

- ICB anti-racism workstream
- ICB CYP workstream
- ICB long term conditions workstream
- ICB MH workstream
- Primary Care Access
- ICB Fuller workstream
- ICB urgent care review
- Access to data & insights

Interdependent Collaborative programmes

- Community collaborative model for health and care
- Primary care collaborative
- Supporting out of borough NEL discharges
- Mental Health collaborative
- Planned Care workstream

Key programmes of work that will deliver the vision and mission

- Improving access to primary and urgent care
- Building resilience and self-care to prevent and manage long term conditions
- Implementing a localities and neighbourhoods model
- Facilitating a smooth and rapid process for hospital discharge into community care
- Being an anti-racist and equity driven health and care system
- Ensuring that Babies, Children and Young People are supported to get the best start in life
- Providing integrated Mental Health services and interventions

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Ensuring residents can equally access high quality primary and urgent care services when and where they need them
- Better prevention of long term conditions and management of existing conditions
- Ensuring that every resident can access the health and care services they need to support their continued health and wellbeing within their local area or neighbourhood, including GP, pharmacy, dental and leisure facilities
- A smooth and rapid process for discharging residents from hospital to suitable community-based care settings when they are ready for this transition
- Ensuring our health and care system and services are achieving equitable outcomes for all residents and addressing inequalities that exist, e.g. access, experience, representation and outcomes
- Ensuring babies, children and young people (and their families) are supported to get the best start in life, especially where they have additional needs
- Providing integrated services and interventions to promote and improve the mental wellbeing of our residents

Key stakeholders:

LBTH
NEL ICB
Barts Health Trust
TH GP Care group
ELFT
Healthwatch
TH CVS

Tower Hamlets residents and service users

Engagement with the public:

The workstreams and the THT Board include VCS and resident stakeholders who input into the design of the programme.

Newham

Portfolio vision, mission and key drivers:
Working with our diverse communities of all ages to maximise their health, wellbeing and independence. Supported by a health and care system that enables easy access to quality services, in your neighbourhood, delivered by people who are proud to work for Newham.

Interdependent ICB programmes
- Babies, Children and Young People
- Fuller
- Long Term Conditions
- Maternity
- Population Health
- Urgent & Emergency Care

Interdependent Collaborative programmes
- Acute
- Community Health
- Mental Health, Learning Disability and Autism
- Planned Care
- Primary Care
- VCSE

Key programmes of work that will deliver the vision and mission
- Joint Planning Groups (JPGs) for Babies, Children and Young People; Mental Health; Learning Disabilities and Autism; Ageing Well; Primary Care; and Urgent Care
- Additional JPG for Long Term Conditions being explored
- Local Authority-led programmes across Health Equity and Well Newham (prevention)
- Population growth programme

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- Reduce the prevalence and impact of long-term conditions on residents' lives
- Enable people to stay well in their own homes by proactively organising and managing their care & support
- Improve the mental wellbeing of residents and ensure people have access to mental health support when and how they need it
- Involve, engage and co-produce all our plans with residents
- Ensure people stay in hospital for the optimum time and are supported to rehabilitate and recover
- Ensure when people need urgent help they can access it quickly and as close to home as possible
- Develop and integrate children's services to ensure children have the best start in life
- Prepare for significant population growth in Newham and North East London and strengthen prevention initiatives

Key stakeholders:
ELFT
Healthwatch
LBN
NEL ICB
NUH
Primary Care
Residents
VCFS

Engagement with the public:
Residents and People & Participation Leads attend Partnership Board, JPGs and project groups

Waltham Forest

Portfolio vision, mission and key drivers:

Our aim is for the population of Waltham Forest to have healthier lives by enabling them to **start well, live well, stay well and age well**, supporting each individual through to the end of their lives. We will do this by working together, as partner organisations and with our residents, **to improve health outcomes and reduce health inequalities.**

- We will engage and involve our residents to coproduce our interventions and services
- We will focus on supporting all residents to stay well and thrive throughout their lives
- We will use population health management approaches to understand the needs of our residents and target our resources to improve equity
- We will ensure when people need help, they can access high quality, good value services quickly and easily and are enabled to stay in their homes or return home as soon as possible.

Key stakeholders:

Interdependent ICB programmes

- ICB anti-racism workstream
- ICB UEC workstream
- ICB CYP workstream
- ICB long term conditions workstream
- ICB MH workstream
- Primary Care Access
- ICB Fuller workstream
- ICB Digital workstream

Interdependent Collaborative programmes

- Whipps Cross redevelopment programme
- MH Collaborative
- Community Collaborative
- Primary care Collaborative
- Planned care workstream

Key programmes of work that will deliver the vision and mission

- Delivery of a programme of locality **prevention, wellbeing and self-care** to intervene earlier with residents to improve health outcomes dentification for intervention and support for residents with **LTCs.**
- Delivery of proactive anticipatory care through delivery of **Care Closer to Home** transformation programme and establishing **Integrated Neighbourhood teams and hubs.**
- Deliver alternative to unplanned attendances and admissions to acute hospital and improve discharge pathways through the delivery of the **Home First programme** of transformation and improving **same day access to primary care.**
- To publish a **children's health strategy** , improve access to **therapies** and reduce the need for children to attend hospital.
- To transform **EOL** services in Waltham Forest to ensure residents have the support to die in their choice of place.
- Publishing a strategy for **children's health**, improving access to children's therapies, and developing services to reduce the need for children to attend Whipps Cross Hospital in an emergency.
- Improving access to **Mental Health** support in community for all ages and promoting positive well-being for all.

Engagement with the public:

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

City & Hackney

Portfolio vision, mission and key drivers:

City & Hackney PbP Vision: Working together with our residents to improve health and care outcomes, address health inequalities and make City and Hackney thrive, by focussing on 3 key areas:

1. **Giving every child the best start in life (often by recognising the role of families)**
2. **Improving mental health and preventing mental ill-health**
3. **Preventing, and improving outcomes for people with long-term health and care needs**

Supporting our population health priority outcome areas (above), we are implementing 6 cross cutting approaches: Increasing social connection, ensuring healthy places, supporting greater financial wellbeing, joining up our local health and care services around resident's and families' needs, taking effective action to address racism and other discrimination, and supporting the health and care workforce. City and Hackney Neighbourhoods programme is about fostering community connections.
Our aim is to improve quality of care (clinical cost effectiveness, experience and safety) including access and waiting times for all our residents particularly those experiencing Health inequalities. We apply the principles of right time, right place, right support.
We acknowledge that the solution lies at "whole-system" level and requires detailed collaboration with wider system partners including local authorities, public health and our voluntary sector partners and strengthening partnership working and synergies to maximise benefits in terms of outcomes and system sustainability. Residents and Families are at the heart of everything we do.
Key drivers: - national and regional policy frameworks, local needs, and addressing areas in C&H where we have poor outcomes and evidence of inequalities (as articulated in JSNAs, Population Health data, and more)

Interdependent ICB programmes

Start Well –BCYP programme priorities on Community Capacity (waiting lists, insights), Primary Care (new models, better integration) Acute care (capacity i.e.. diabetes, allergy)
Live Well - LTC and Specialised Commissioning; Planned Care; Urgent and Emergency Care; Personalised Care
Age Well - Palliative & End of Life Care; NEL Care Home / Care Provider Forum / Network; Continuing Healthcare: NEL Carers Network
Mental Health - Children (C&H); Unplanned / Crisis Care (C&H); Community Care (C&H); NEL MH Delivery Group

Interdependent Collaborative programmes

Start Well – APC, Community Collaborative (Waiting lists, SLT), Mental health collaborative, C&H CAMHS Alliance, Primary Care Collaboratives
Live Well – APC; Community Collaborative
Age Well - Mental Health Alliance; Primary Care Collaboratives
Mental Health - Mental Health Integration Committee (MHIC); C&H Children's Emotional Health and Wellbeing Partnership; C&H Psychological Therapies and Wellbeing Alliance (PTWA); C&H CAMHS Alliance; C&H Dementia Alliance; C&H Primary Care Alliance; Hackney SIG

Key programmes of work that will deliver the vision and mission

Start Well – CAMHS / Improving wellbeing and MH (ACEs), improving outcomes for CYP with SEND, complex health needs, ASD and LD, increasing immunisations and vaccinations, reducing maternity inequalities and improving perinatal mental health
Live Well - Neighbourhoods (Proactive Care, Community Navigation); Better Care Fund Partnership; Primary / Secondary Care Interface; Long Term Conditions Management
Age Well - Discharge Improvement Programme; Integrated Urgent Care - NEL Same Day Access Programme, Enhanced Community Response (Virtual Wards and Urgent Community Response), Frailty / Proactive Care
Mental Health - ADHD / ASD Assessment and Aftercare (All ages) – Backlog and Waiting times; Adult Talking Therapies – Integrated Pathways. Quality Improvement. Demand / Capacity and Waiting Times; Community Transformation / Continued Improvement with Neighbourhoods offer – aligning existing provision; Neurodevelopmental Pathways Review (CYP); Crisis / T3.5 Pathways Review (Including ICCS, Surge and IST); Whole System Approach (iThrive) – CYP Emotional Health and Wellbeing Continue to enhance THRIVE working with Schools (WAMHS / MHSTs integration) / Youth Hubs (Super Youth Hub); SMI Pathway Improvement
Improving and optimising 117 Aftercare;

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

All our work is aimed at improving the health and wellbeing of our local residents and reducing inequalities

Start Well

- Reductions in crisis mental health presentations to ED for CYP and Improvements in mental health and wellbeing outcomes for specific communities
- An increase % of children achieving good level of development - Improved health and educational outcomes for those at risk of exclusion and those with complex needs, SEND and autism and LAC
- Increase immunisation coverage
- A reduction in infant mortality rate, and in the rate of neonatal mortality and stillbirths, including a reduction in inequalities in maternity and birth outcomes for children and families. Improvements in patient experience.

Live Well and Age Well

- Patients will feel safe and supported with any ongoing care needs following a hospital admission
- Patients will know about services are available and have increased confidence in them to meet their needs
- Patients feel supported to access the care they need
- Patients will have more care being provided outside hospital, closer to their home, where appropriate

Mental Health

- ***Improved experience, waiting times and overall quality of care*** - Neurodevelopmental assessment (CAMHS and Adults); Psychological therapies intervention (CAMHS and Adults); 117 Aftercare; Wellbeing in School and Youth Hubs; Crisis Care including Crisis prevention and wellbeing
- ***Better meeting the needs of residents who experience greater health inequalities*** - Protected characteristics – Equalities act; Social deprivation; Serious mental illness; Neurodevelopmental (ASD / ADHD / LD); Looked After Children / Care Leavers].

Key stakeholders:

- Residents / Carers
- Local Authorities and the CoL (ASC; PH; MH; LD&A)
- Voluntary& Community Sector;
- Homerton Hospital
- ELFT
- LBH / CoL – Adult Social Care
- LBH CoL – Children Social Care
- Hackney Education
- ELFT – CAMHS / Adults
- HUH CAMHS / Adults / Acute / Paediatrics
- C&H Public Health
- Primary Care / GP Confed
- VSO Partners / SIG

Engagement with the public:

- Healthwatch
- Programme / Project Service-user reps
- Engagement with the public
- Advocacy Project (MHIC)
- Alliance coproduction and Participation
- Maternity voices partnership
- SEND parent carer forum

Health Inequalities

Portfolio vision, mission and key drivers:
Health inequalities exist between NEL and the rest of the country – for example we have particularly high rates of children with excess weight and poor vaccination and screening uptake – but they also exist between our places and communities. These inequalities are avoidable and unfair and drive poorer outcomes for our population. We want to improve equity in access, experience and outcomes across NEL. To do this we have made reducing health inequalities a cross-cutting theme that is embedded within all of our programmes and services within places and across NEL – everyone has a role to play.

Key stakeholders:
Public health teams
Local authority departments
Voluntary and community sector
Primary care
NHS trusts
NHS E and TPHC
ICB

Key programmes of work that will deliver the vision and mission
- Dedicated health inequalities funding has been provided to each place-based partnership to lead locally determined programmes to reduce health inequalities within their local communities. These projects will be evaluated and the learning shared and showcased.
- Development of a NEL Health Equity Academy to support all people and organisations working in health and care in NEL to be equipped with the knowledge, skills and confidence to reduce health inequalities for the benefit of local people
- Implementation of a community pharmacy scheme to provide targeted pharmacist advice and free over the counter medicines for people on low incomes and experiencing social vulnerability across NEL, to support our communities in the context of cost of living pressures.
- Taking a Population Health Management (PHM) approach, led by places and neighbourhoods, will support frontline teams to identify high risk groups and identify unmet need. A PHM Roadmap has been developed for NEL and is being implemented.
- Embedding the NEL Anchor Charter, working with system partners to ensure we are measuring and creating the opportunities that being an anchor institution affords are leveraged for our local population, to address structural inequalities such as ensuring the NHS in NEL is a London Living Wage accredited employer, embedding social value in procurement process and better utilising our infrastructure to support community activation and supporting a greener, healthier future.
- Delivering our ICS Green Plan including developing an Air Quality Programme, ICS wide net zero training programme, and embedding net zero into our procurement processes to support our aim of reducing our collective carbon footprint by 80% by 2028 and to net zero by 2040.
- Improving access to primary care for health inclusion groups (homeless and refugee and asylum seekers) through safe surgery programme, supported discharge for homeless through the out of hospital care programme, supporting families in temp accommodation to access support out of borough, commissioning a NEL wide initial health assessment for those seeking sanctuary housed in contingency accommodation, and commissioning a needs assessment for health inclusion in NEL to identify needs for other underserved groups that require focus.

Details of engagement undertaken with Places, collaboratives and other ICB portfolios
- NEL Population Health and Inequalities Steering Group is made up of representatives from places and collaboratives, and leads from across the ICS.
- Significant engagement across the system on what is useful from a Health Equity Academy
- Engagement from across the system on Anchors, Net-zero and health inclusion around homelessness and refugee and asylum seeker programmes

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- Reduced differences in health care access, experience and outcomes between communities within NEL, particularly for people from ethnic minority communities, people with learning disabilities and autism, people who are homeless, people living in poverty, and for carers.
- Improved health life expectancy for all communities across NEL, irrespective of who you are or where you live.
- Our population receives more inclusive, culturally competent and trusted services, underpinned by robust equity data.

Engagement with the public:
Engagement on specific topics, and in depth at place level.

Prevention

PLACE

HOLDER

SLIDE

<SLIDE IN DEVELOPMENT>

Personalised Care

PLACE

HOLDER

SLIDE

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Learning System

Portfolio vision, mission and key drivers:

The transition to an Integrated Care System has provided an opportunity to work in a different way in how we deliver and approach change to services within north east London. In order to improve the care we provide our residents, it is crucial to embed the improvement process of learning from the current delivery. As such the ICB needs provide an environment that facilitates the ability to deliver a systematic approach to iterative data-driven improvement

To ensure an effective learning system, the organisational culture must support a strong learning approach. The three stage learning cycle (learning before, during and after) describes how staff can interact with the learning system to inform their work. Each stage is informed by the following principles:

- We are well-informed – before we act, we fully consider the impact of our decisions on individual, community and system outcomes and equity.
- We are responsive – we are effectively monitoring our interventions and taking action in a timely manner
- We reciprocate –we work together sharing knowledge openly and valuing collaboration over competition

Key stakeholders:
Quality and safety
Complaints
Strategy
Programme Management Office
Place-based directors

Key programmes of work that will deliver the vision and mission

Initial scoping still to be concluded and so no programme of work has been developed/

Details of engagement undertaken with Places, collaboratives and other ICB portfolios

First discussion meeting yet to take place and so as yet no engagement has taken place

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

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- Participation in evidence-informed decision making, promoting legitimacy
- Development of a localised evidence-base, helping us to make decisions most suitable to our context and populations
- Reduction in duplication, improving productivity and sustainability
- Proportionate approaches to transformation, improvement and innovation, not driven by whim or external pressures

Engagement with the public:

First discussion meeting yet to take place and so as yet no engagement has taken place with Places, collaboratives and other ICB protfolios

Co-Production

PLACE

HOLDER

SLIDE

<SLIDE IN DEVELOPMENT>

High Trust Environment

PLACE

HOLDER

SLIDE

<SLIDE IN DEVELOPMENT>

6. Implications and next steps

Lessons Learnt (in development)

PLACE

HOLDER

SLIDE

<SLIDE IN DEVELOPMENT>

('Early lessons from work to develop this plan' - slide being amended)

How will we know we have succeeded - NEL Outcomes Framework

- The interim North East London Integrated Care Strategy was published and adopted by the Integrated Care Board in January 2023.
- The strategy highlights our four system priorities for improving quality and outcomes and address health inequalities as well as our six crosscutting themes which are part of the new approach for working together across NEL.
- The strategy was developed in conjunction with system partners, along with a set of 61 success measures, which aimed to measure delivery against the priorities and crosscutting themes.
- This slide deck outlines the steps we are proposing to develop an outcomes framework.

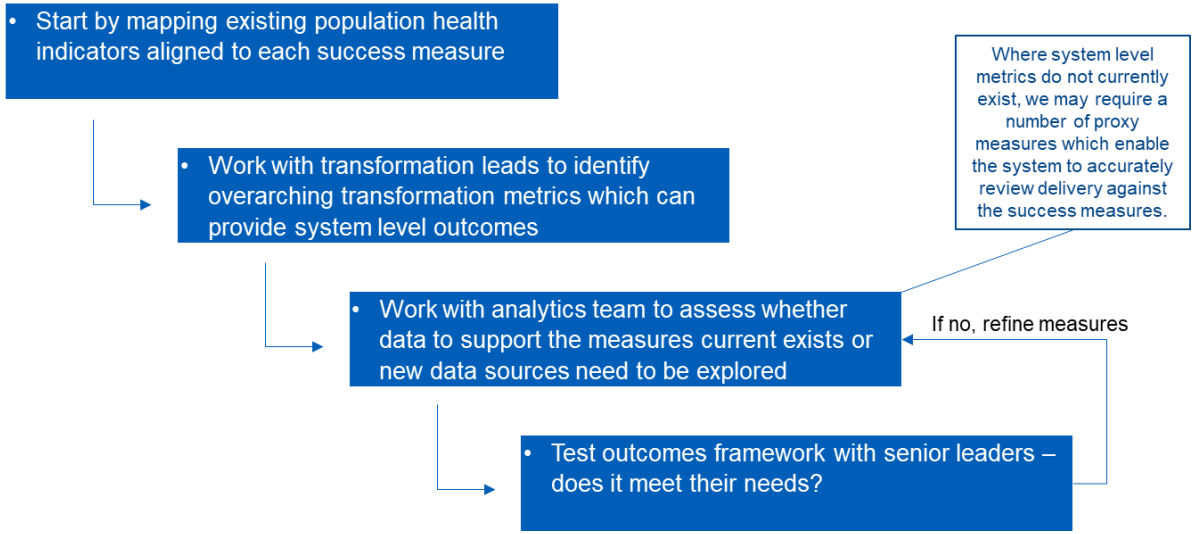
What do we mean by an outcomes framework?

- An outcomes framework is a way for us to measure the effectiveness of our ICS strategy by focusing on the outcomes that are achieved, rather than just the activities that are carried out. That way we can assess whether our strategy is making a positive difference in people's lives.

In order to support the development of the outcomes framework, the below principles have been drafted to shape the design and implementation:

- **Assess delivery against ICS strategic themes and objectives**
- **Demonstrate current delivery on priority areas**
- **Develop outcome measures in conjunction with transformation leads, provider collaboratives, and ICS partner organizations**
- **Avoid developing an outcomes framework in the model of a performance framework**
- **Importance of recognising that outcomes are often long-term goals**
- **Assess wider population health measures rather than focus on statutory or mandated targets**
- **Make the system responsible for delivering metrics**

The NEL approach



Next steps for our transformation programmes

- 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 to the more specific challenges described in the first half of this plan is more variable.
- Our shared task now is 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 with local people.

Technical work

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

- the **quantifiable beneficial impact** on local people, 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, and 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.

We will continue to evolve as a system

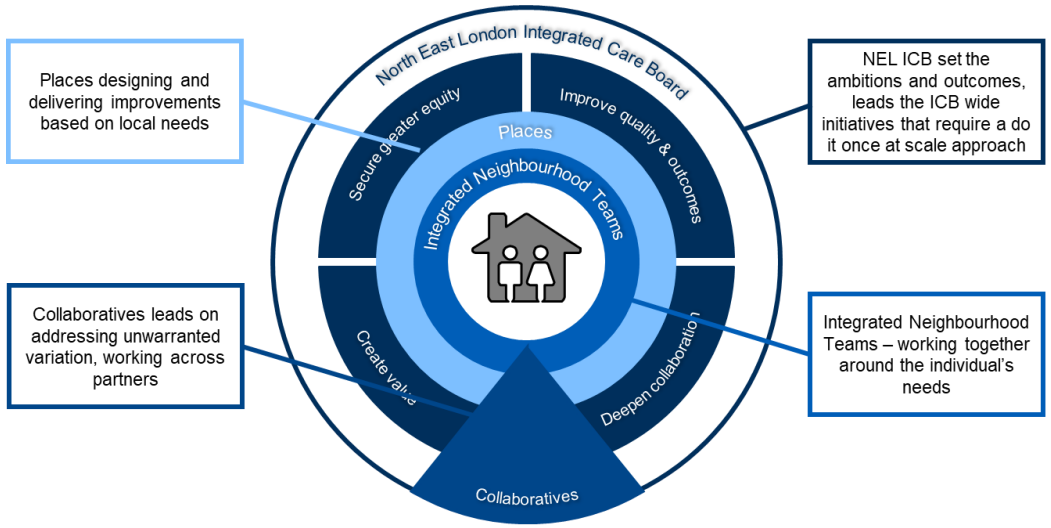
Our system has been changing rapidly over recent years, including the inception of provider collaboratives, the launch of seven place based partnerships, the merger of seven CCGs followed by the creation of the statutory integrated care board and integrated care partnership in July 2022.

Since becoming an ICS we have designed our way of working around teams operating:

- At **Place** delivering services and improvement for Neighbourhoods and Place;
- In **Collaboratives** reducing unwarranted variation, driving efficiency and building greater equity;
- For **NEL** sharing best practice, implementing NEL solutions for NEL work, providing programmatic support and oversight, and delivering enabling functions to our organisation and ICS through a business partner model.

Coordination between our Places, Collaboratives and NEL wide programmes is critical so that we:

- Operate as a learning system and spread best practice
- Ensure that activity, transformation and engagement happens at the most appropriate level, duplication is reduced and tensions are identified and resolved
- Identify where there is NEL work which should be done once for NEL
- Deliver value for money
- Deliver beneficial and sustained impact for the health and wellbeing of local people.



We are now looking to work with our partners to further develop how we work together, underpinned by our ambition to create a **High Trust Environment** that supports integration and collaboration and to operate as a **Learning System** driven by research and innovation.

Designing together *how* we want to work will be as critical as agreeing *what* we want to deliver.

This will help us get greater clarity on the responsibilities of different parts of the system, and critically how we want each part of the system to interact with another to enable integration and continuous improvement.

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NHS
North East London

Patient Choice

April 2024

Patient Choice of hospital or service

Under the NHS Constitution, patients have a legal right to choose which hospital or service they are referred to;

“you have the right to make choices about the services commissioned by NHS bodies and to information to support these choices”

This applies to both physical and mental health (including learning disabilities and autism) services

Patients can also choose any clinically appropriate team led by a named consultant employed by that provider.

Providers must a hold a qualifying NHS Standard Contract, this can be with any ICB or NHS England, **for the service required by the patient at the chosen site.**

NB. The referrer is not required to make a referral to a provider or team if they do not believe this would be clinically appropriate.

NHS Choice Framework - what choices are available to you in your NHS care - GOV.UK (www.gov.uk)

Patient Choice – the exceptions

This applies to all referrals to consultant led services* made by GPs, Dentists or Optometrists with the follow exceptions:

- Urgent and Emergency Care or Crisis services
- Cancer services (subject to the Faster Diagnosis Standard)
- Maternity Services
- Services commissioned by Local Authorities eg Public Health services.

The obligations to offer choice of provider and team do not apply to any person already receiving care and treatment for the condition they are being referred for (although it does apply for new episodes of care regardless of whether a patient has been seen for a condition previously).

They also do not apply when a patient is detained under the Mental Health Act 1983, detained or on temporary release from prison or serving as a member of the armed forces.

For mental health referrals, choice can also apply to first outpatient appointments with other appropriate healthcare professional led teams and not just consultant led care.

How it works!

- Once a decision has been made to refer, the GP, dentist or optometrist should discuss the different provider options with the patient, this might include relative waiting times, location, clinical outcomes.
- The referrer can either use the NHS e-Referral system (eRS) to book an appointment straight away. Alternatively, they can issue an appointment request, with a shortlist of providers, to the patient for them to make an appointment on eRS once they've had time to think about when and where they want to be seen.
- Patients can access more information on hospital and services including average waiting times from My Planned Care NHS
- A GP can also use eRS to seek advice from a specialist prior to or instead of a referral. This is called Advice and Guidance.

How it works!

- If a patient feels they have not been offered choice, first they need to speak to their GP. If they are still not satisfied, they can make a complaint to the ICB responsible who will try to resolve the issue.
- A patient can ask to be referred to a different provider of NHS services if:
  - they have to wait, or have already waited, more than 18 weeks before starting treatment or assessment for a physical or mental health condition, as long as the referral is not urgent and the service you require is led by a consultant
  - they have to wait, or have already waited, more than 2 weeks to see a specialist for suspected cancer

What NHS NEL is doing to support choice!

- NHS North East London has nominated an SRO for Choice, Charlotte Pomery, Chief Officer for Participation and Place
- NHS NEL is promoting and raising awareness of Choice with patients and GPs. Patient choice: where can I have treatment - NHS North East London (icb.nhs.uk)
- Has set up a system to accredit and award contracts to new providers who wish to provide services in North East London.

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