North East London Health & Care Partnership

NHS
North East London

DRAFT

North East London (NEL) Joint Forward Plan

March 2023

1. Introduction

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

Improve quality & outcomes	Deepen collaboration	Create value	Secure greater equity

6 Crosscutting Themes underpinning our new ICS approach

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

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

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

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

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

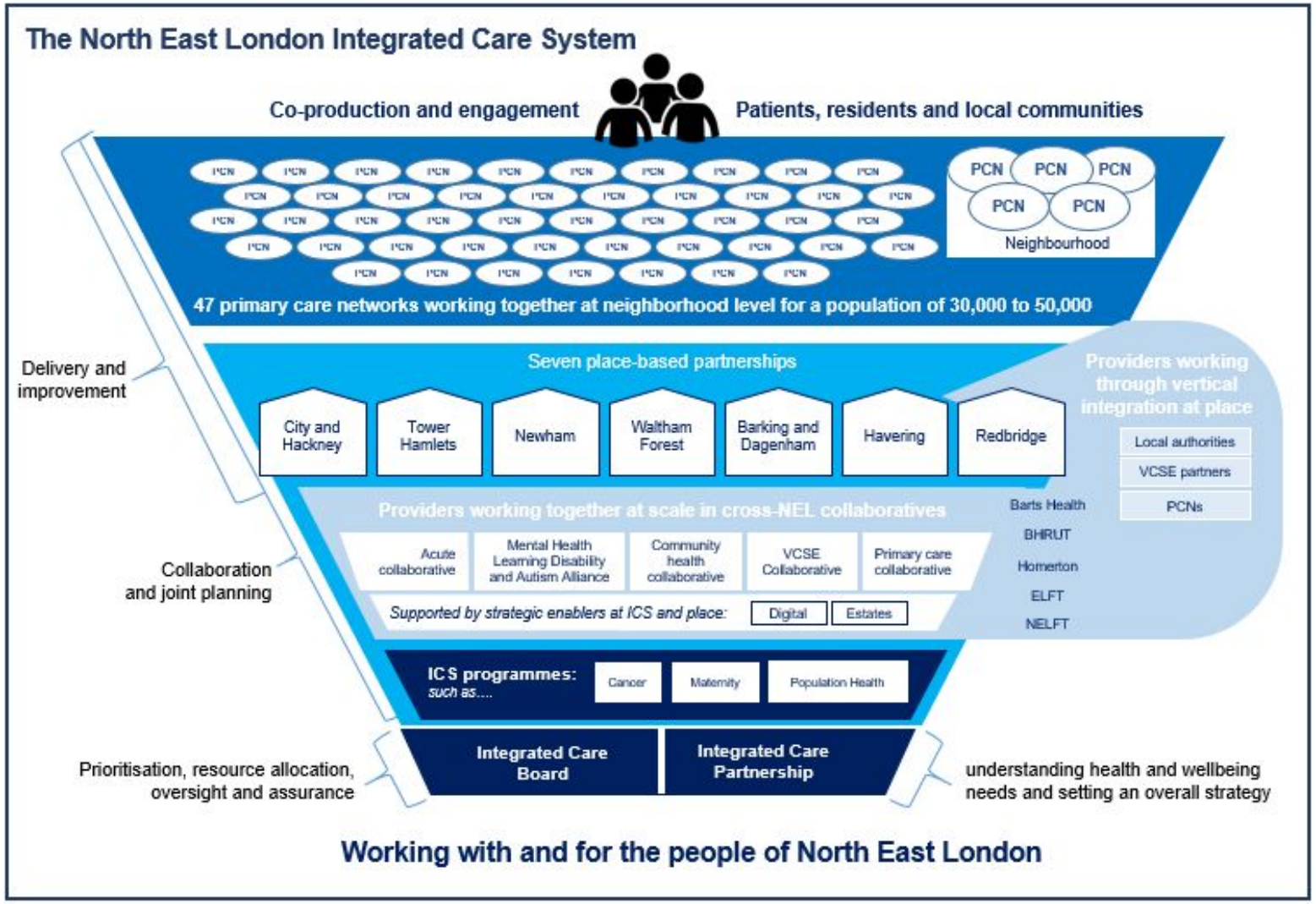
We are a broad partnership, brought together by a single purpose: to improve health and wellbeing outcomes for the people of north east London.

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

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

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

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



2. Our unique population

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

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

Rich diversity

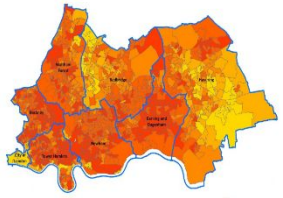
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from ethnic minority backgrounds.

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

Young, densely populated and growing rapidly

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

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



Poverty, deprivation and the wider determinants of health

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

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

Stark health inequalities

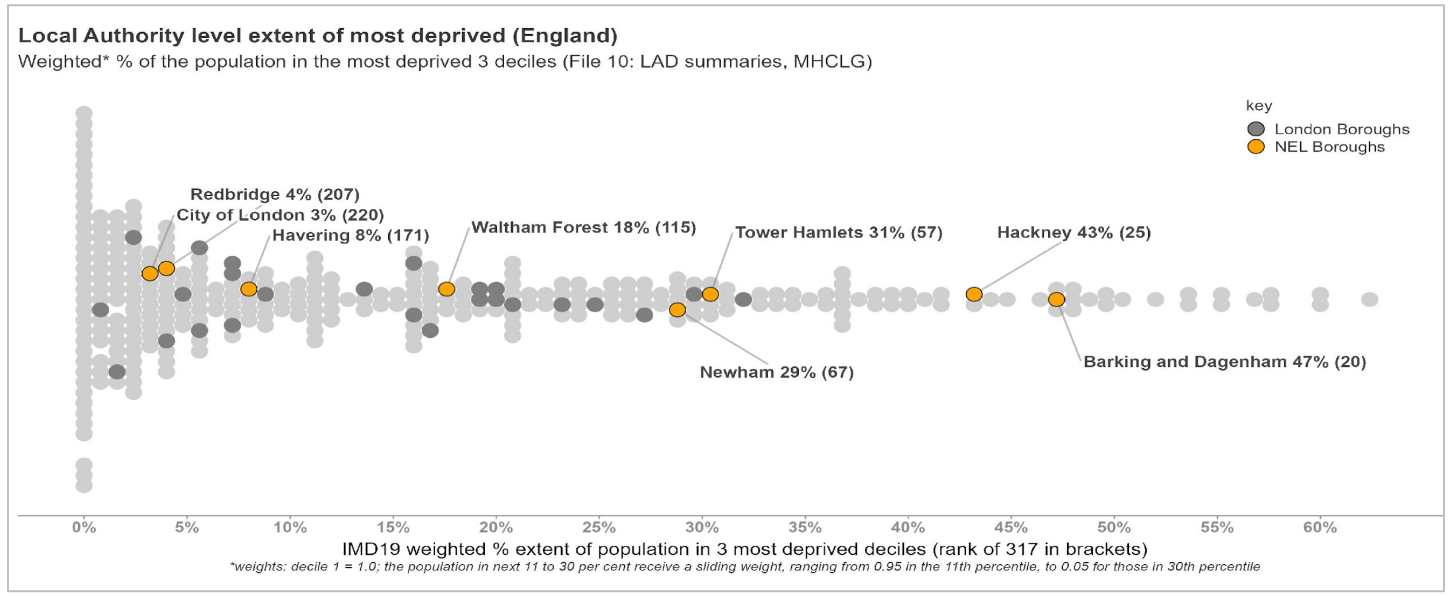
There are significant inequalities within and between our communities in NEL, and our population has worse health outcomes than the rest of the country across many key indicators. Health inequalities are linked to wider social and economic inequalities including poverty and ethnicity.

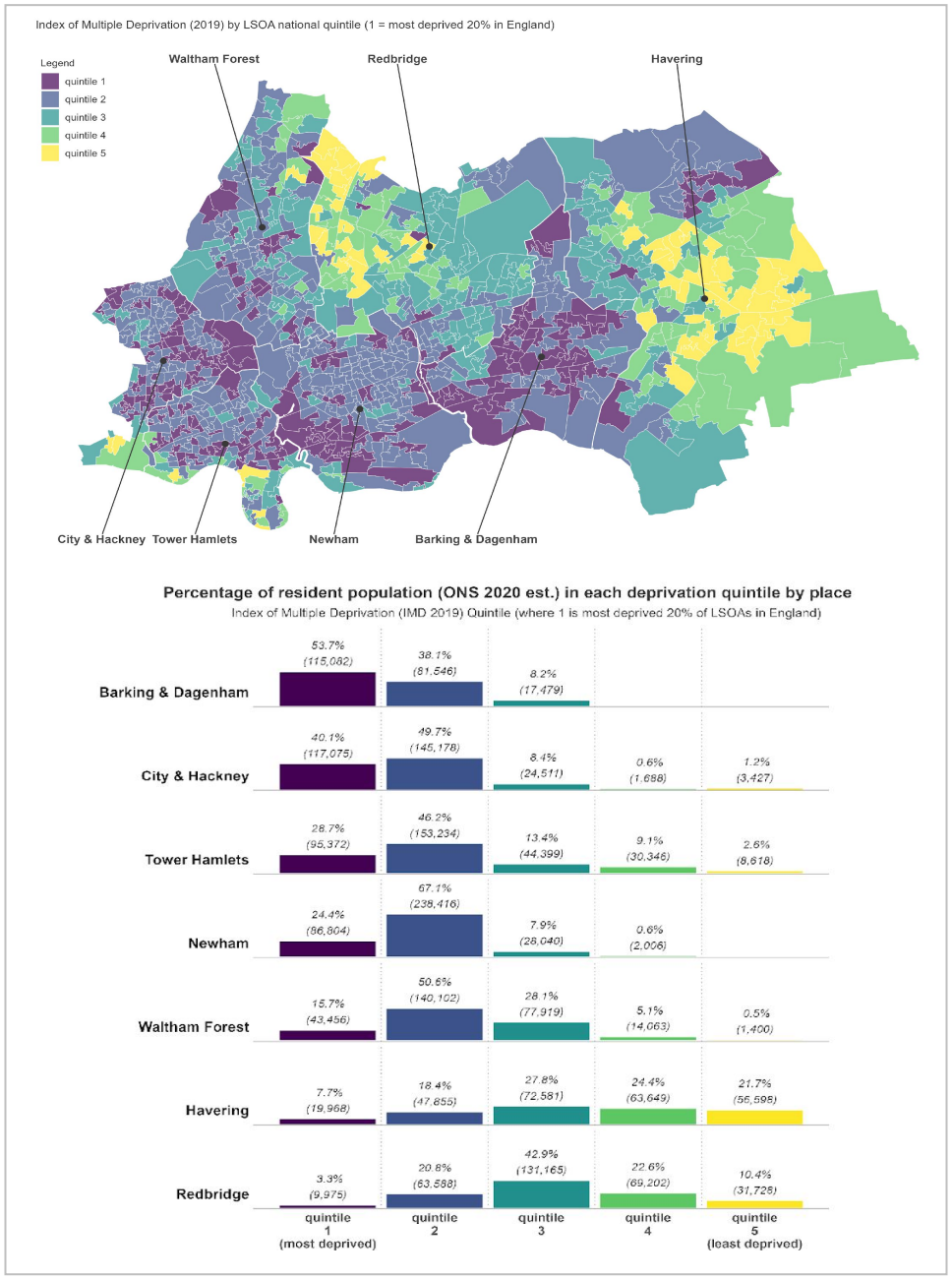
Our population has been disproportionately impacted by the pandemic and recent cost of living increase.

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

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

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





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

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

Child Obesity

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

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

Mental Health

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

Tobacco

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

Premature CVD mortality

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

Vulnerable housing

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

Homelessness

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

Childhood Poverty

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

Childhood Vaccinations

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

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

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

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

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

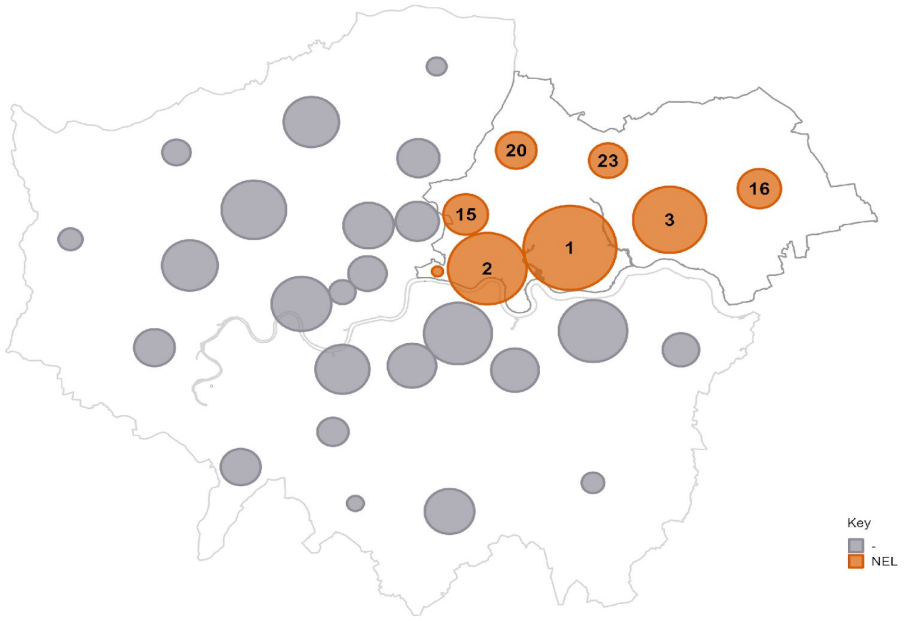
The population of north east London (currently just over 2 million) is projected to increase by almost 15% (or 300k people) between 2023 and 2040, the equivalent to adding a whole new borough to the ICS, and by far the largest population increase in London.

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

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

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

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

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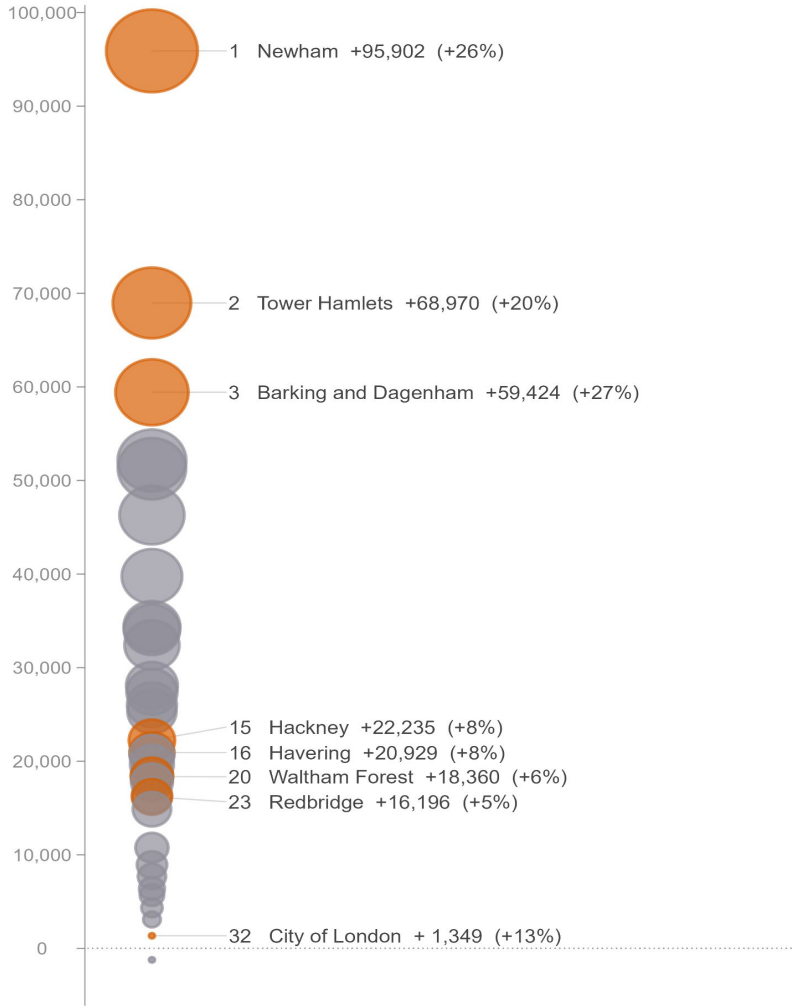


GLA Identified Capacity Scenario, published September 2021, 2020 based

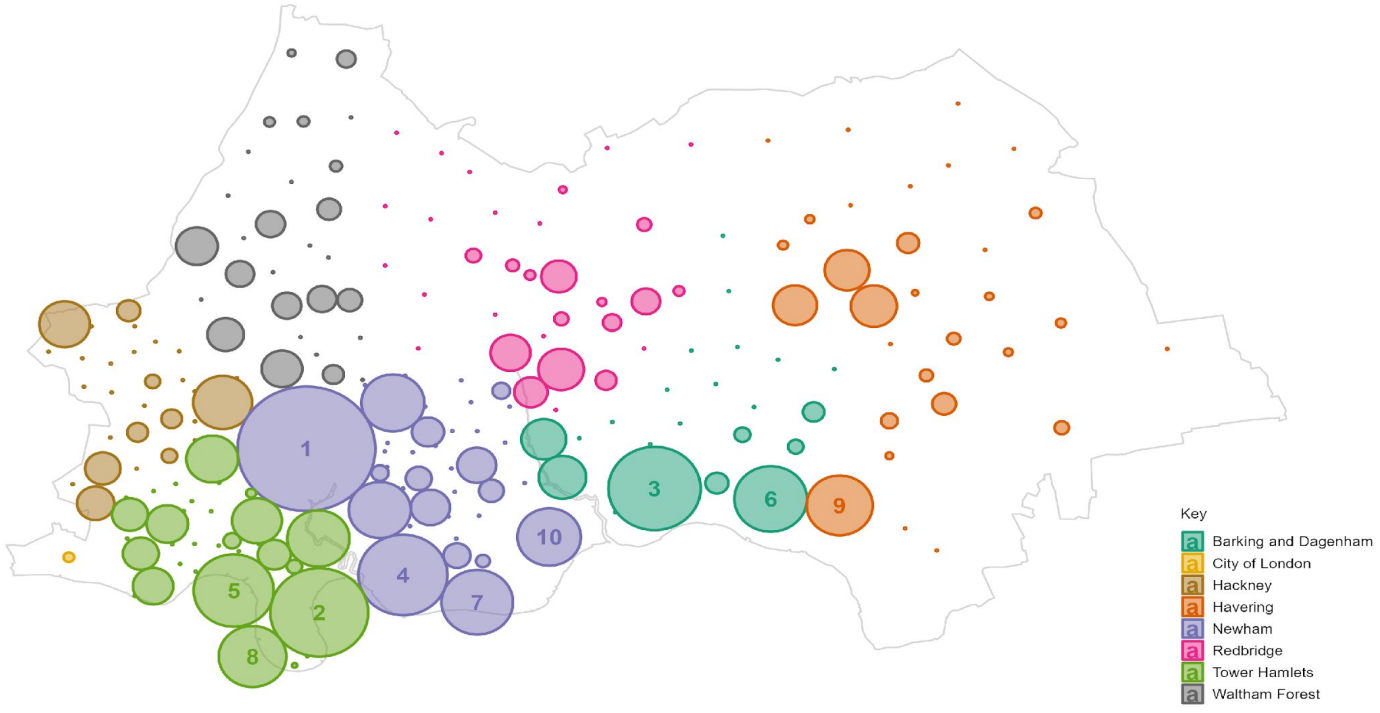
We need to act urgently to improve population health and address the impact of population growth

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

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

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

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



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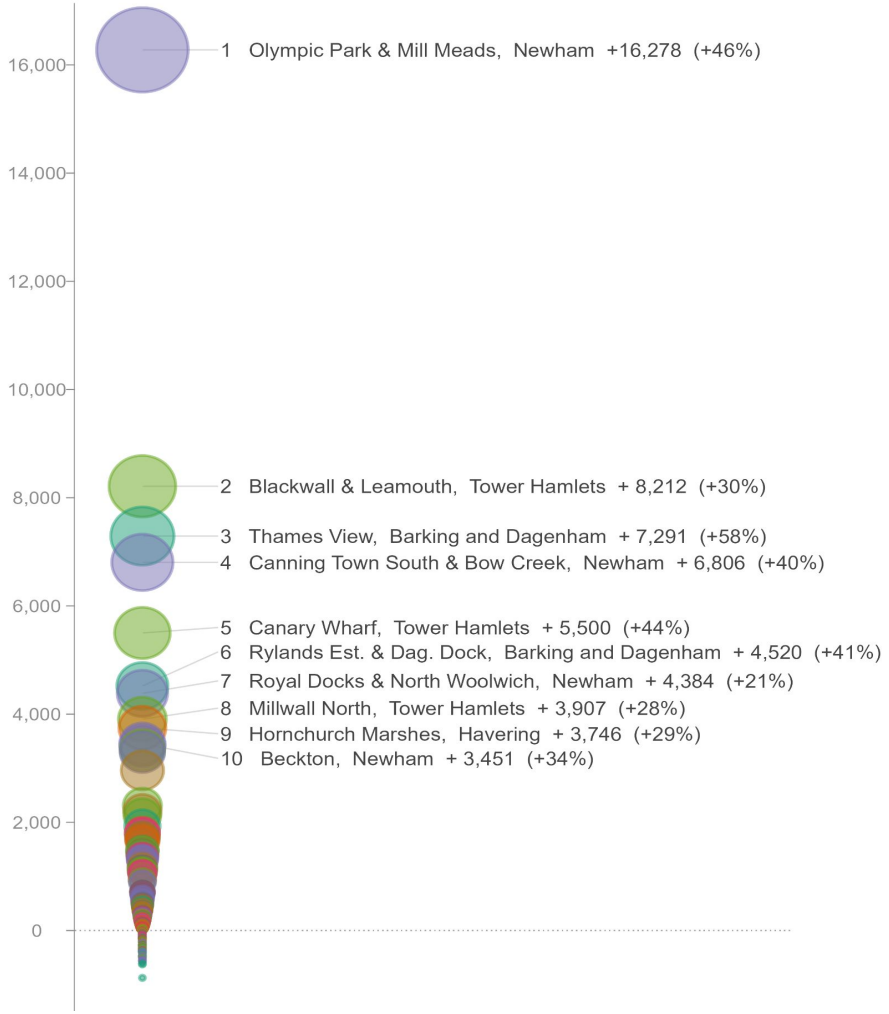


3. Our assets

We have significant assets to draw from

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

Our assets

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

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

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

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

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

Our health and care workforce is our greatest asset

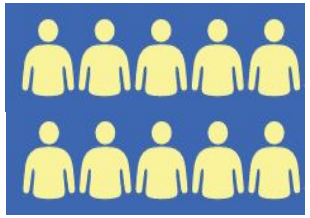
To be updated during April-June in line with People Strategy currently under development

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

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

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

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



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

Our workforce includes -

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

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

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

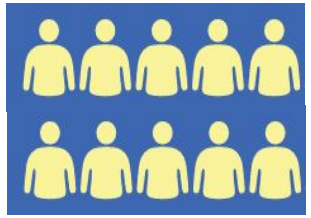
In NEL we are supporting the development of a VCSE Collaborative to create the enabling infrastructure and support sustainability of our rich and diverse VCSE in NEL, also ensuring that the contribution of the VCSE is valued equally.

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

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

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

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



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

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

4. Our challenges and opportunities

The key challenges facing our health and care services

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

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

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

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

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

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

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

We face substantial pressures on same day urgent care

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

We have a large backlog of people waiting for planned care

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

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

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

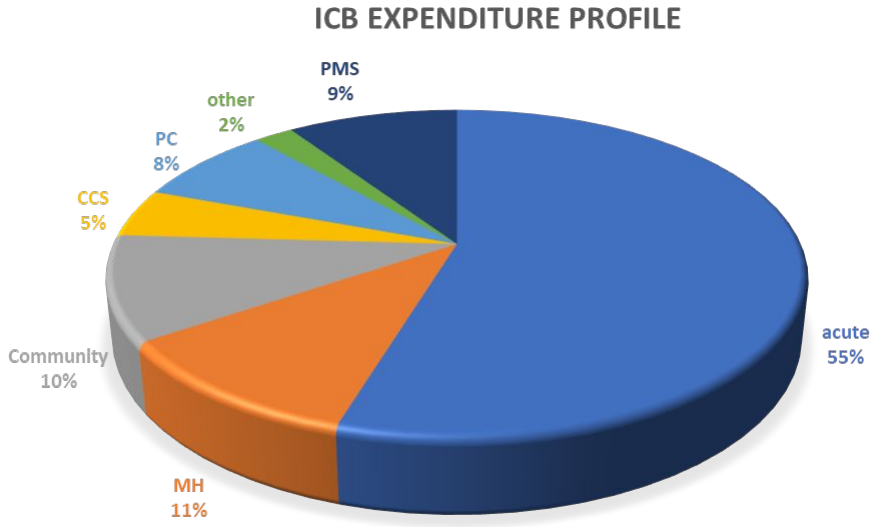
- North east London currently has relatively few GP appointments per 100,000 weighted population (39,244 vs a median for all ICSs of 42,360 – i.e. the national median is around 8% greater than in NEL), suggesting part of the cause of pressure on other parts of the system, including greater than expected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

Long term conditions

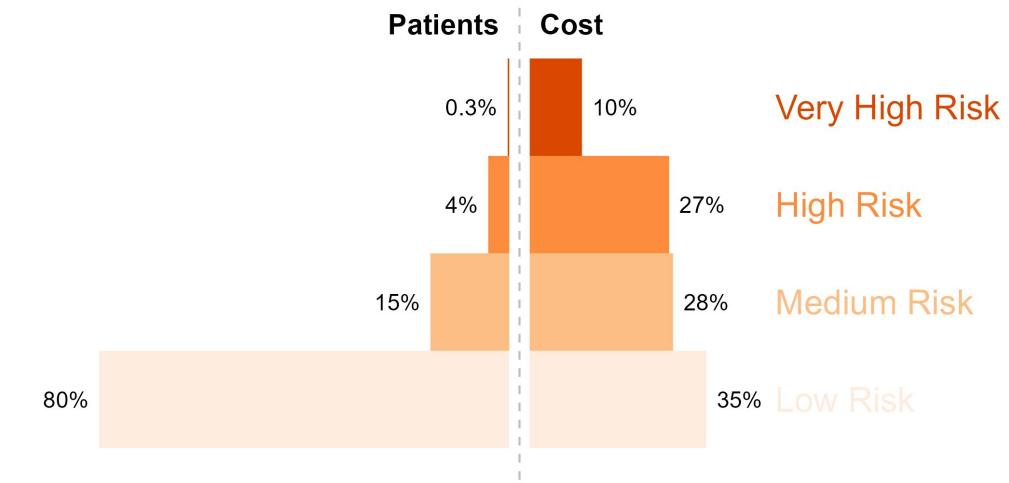
- Across north east London one in four (over 600 thousand people) have at least one long term condition, with significant variation between our places (in Havering the figure is 33%, vs 23% in Newham and Tower Hamlets).
- Age and deprivation are strong predictors of long term conditions, so while north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

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

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



Risk stratified cost of emergency admissions



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

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

5. How we are transforming the way we work

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

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

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

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

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

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

2. Our NEL strategic priorities

3. Our supporting infrastructure

4. Local priorities within NEL

A quick snapshot of NEL's transformation work

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

By April 2024

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

Urgent and emergency care

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

Over the next two years

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

Over years three to five

- Further development of virtual consultations for U&EC

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Community health services

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Primary care

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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

Planned care and diagnostics

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

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

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

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

Key programme features and milestones:

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

Key milestones include:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Cancer

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

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

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

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

Key programme features and milestones:

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

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Maternity

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Babies, children, and young people

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

Over the next two years to five years

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Long-term conditions

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

April 2024:

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

April 2026:

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

Over the next two years

- Improve acute stroke standards and flow across the stroke pathway

Over years three to five

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Mental health

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

April 2024:

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

April 2026:

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

Over the next two years

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

Over years three to five

- Comprehensive digital offer underpinning NEL mental health and emotional wellbeing approach
- Lived Experience-Led crisis service developed

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Employment and workforce

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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

Physical infrastructure

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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

Digital infrastructure

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Further programmes

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

6. Implications and next steps

Early lessons from work to develop this plan

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

Analysing our transformation portfolio - i

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

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

Analysing our transformation portfolio - ii

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

Analysing our transformation portfolio - iii

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

Next steps

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

Technical work

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

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

Engagement

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

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

7. National planning requirements lookup tables

Links to other plans and strategies

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

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

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

Annex 8. Engagement plan

How we engage with our partners on the Joint Forward Plan

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

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

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

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

Annex 9A - demand projections

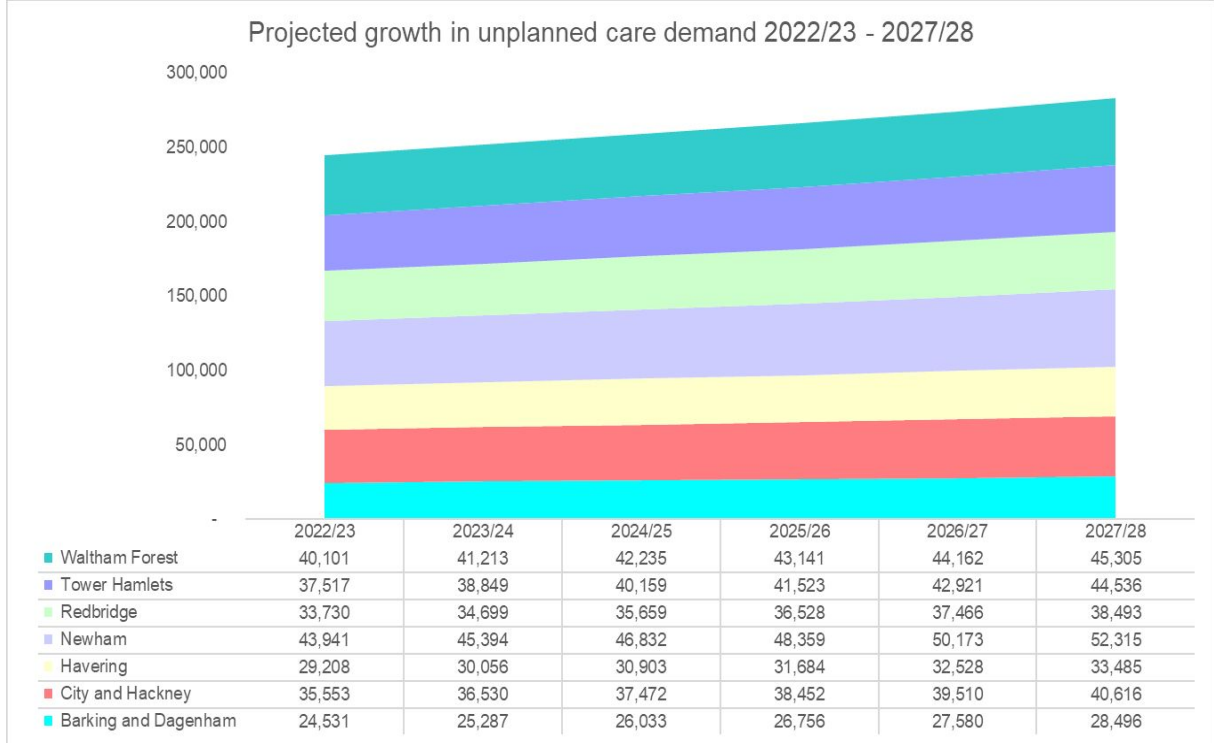
Demand projections for UEC

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

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

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

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

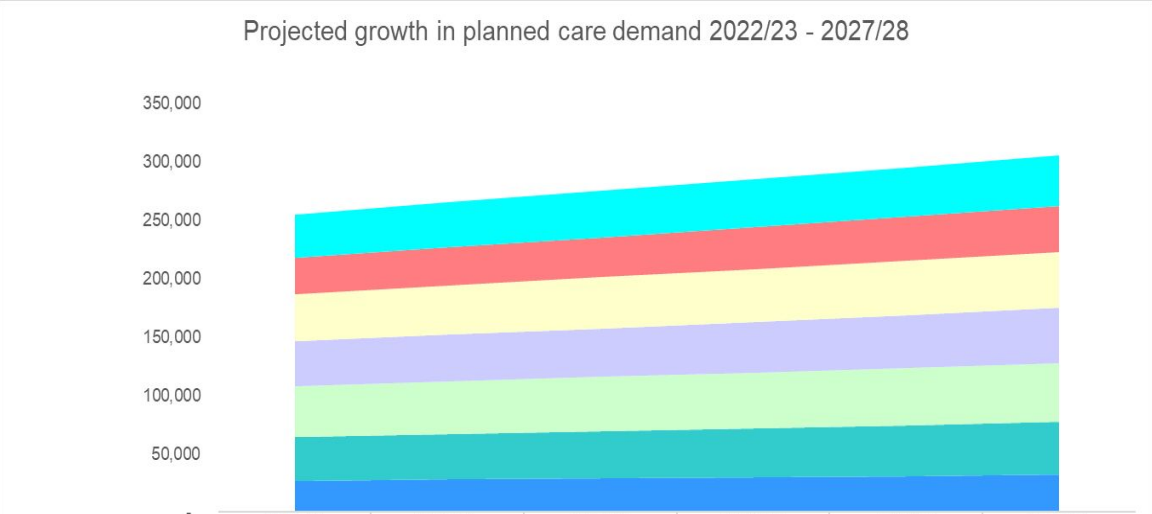


	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
Waltham Forest	40,101	41,213	42,235	43,141	44,162	45,305
Tower Hamlets	37,517	38,849	40,159	41,523	42,921	44,536
Redbridge	33,730	34,699	35,659	36,528	37,466	38,493
Newham	43,941	45,394	46,832	48,359	50,173	52,315
Havering	29,208	30,056	30,903	31,684	32,528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

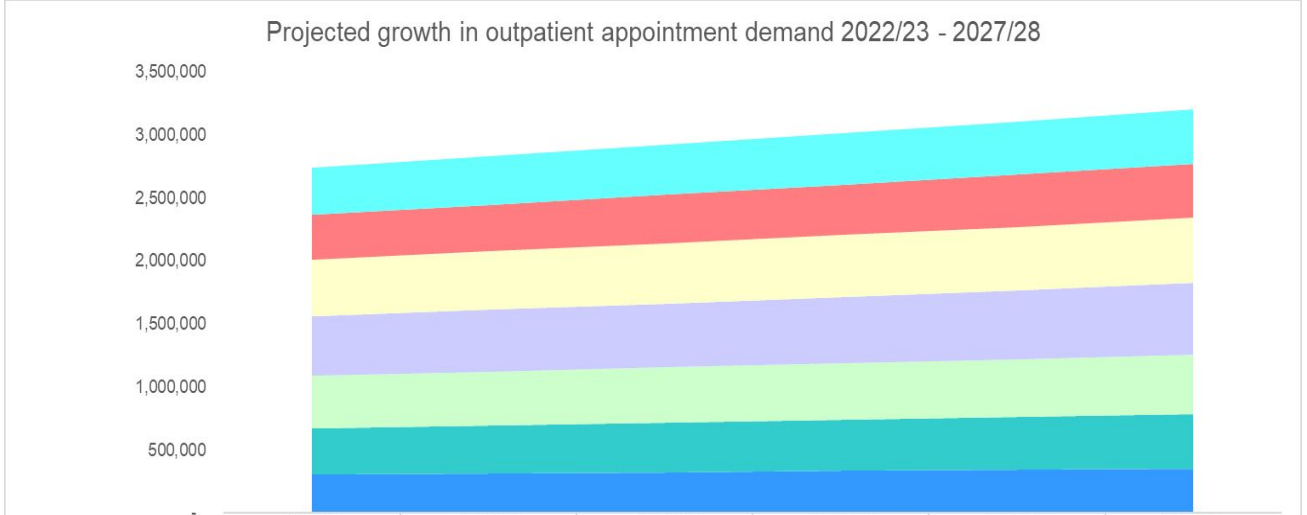
Figures are based on modelling by the NEL Insights Team which uses GLA population growth projections

Demand projections for planned care

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



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



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

Demand projections for diagnostics

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

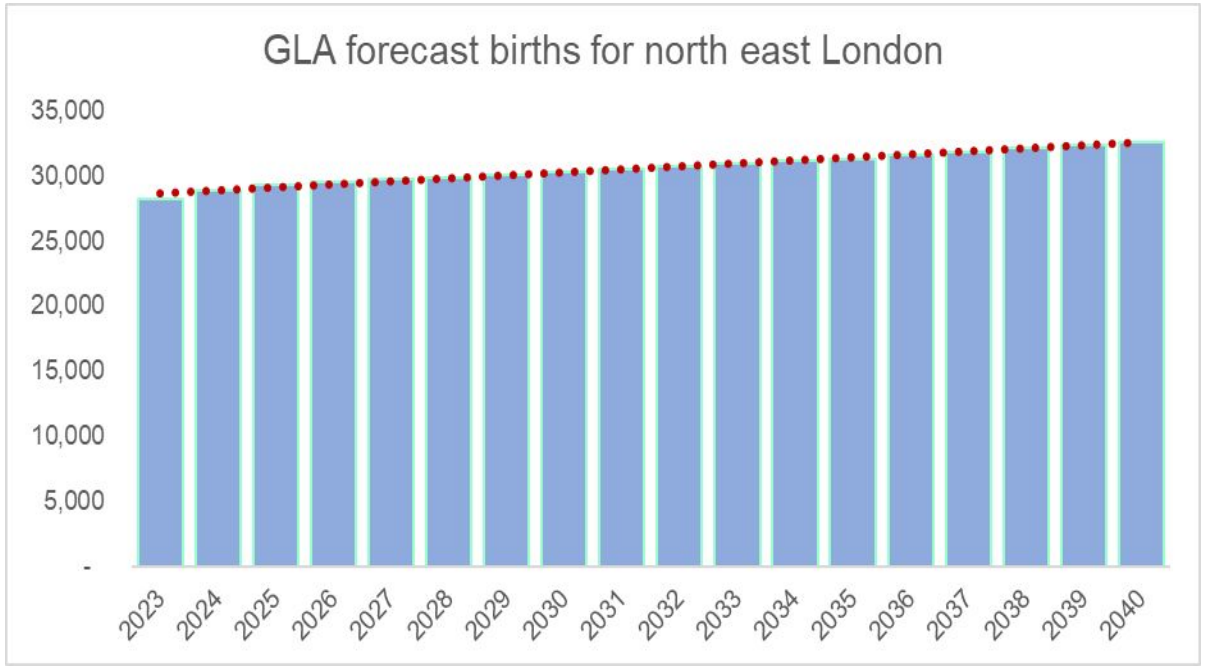
Imaging diagnostics projected demand growth 2022/23 - 2027/28								
	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Growth	5 year trend
Cone Beam CT	1,515	1,557	1,599	1,643	1,690	1,738	14.7%	
CT Scan	214,182	223,675	233,001	242,000	251,320	261,346	22.0%	
Endoscopy	1,668	1,744	1,818	1,888	1,962	2,041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

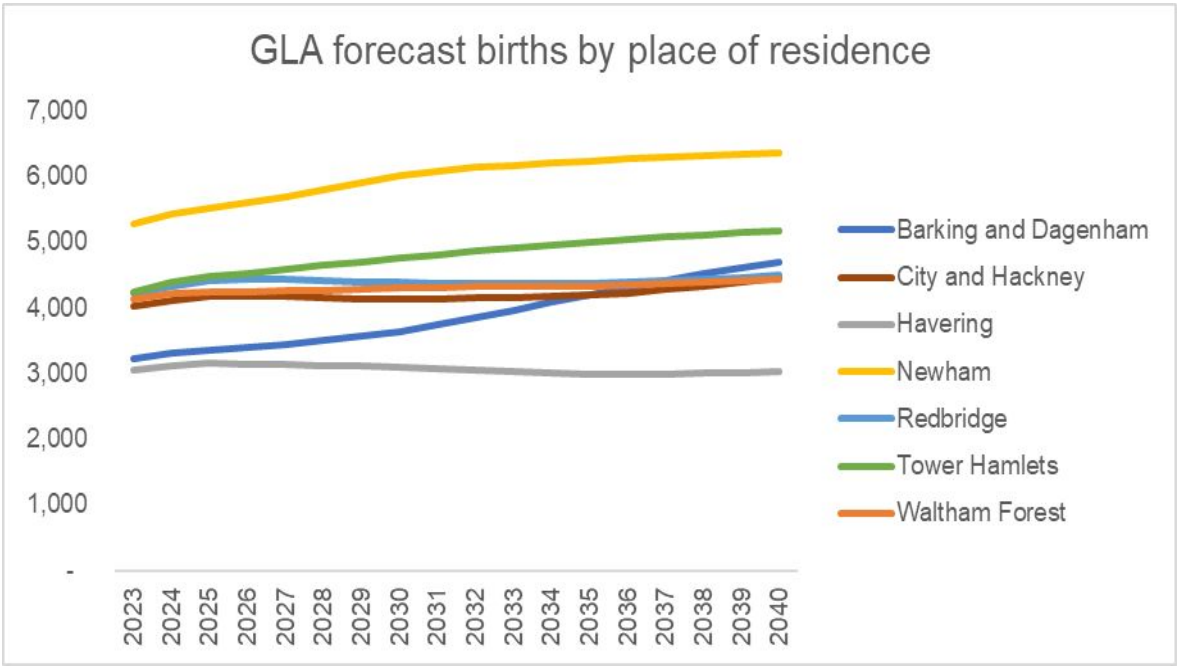
Demand projections for maternity

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

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

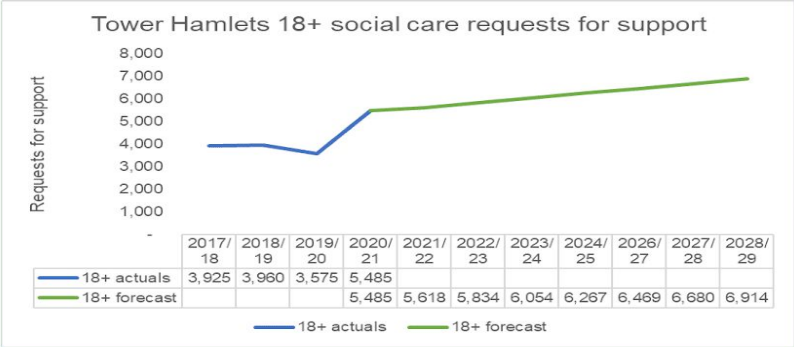
Havering forecast a reducing number of births between 2026 and 2036.



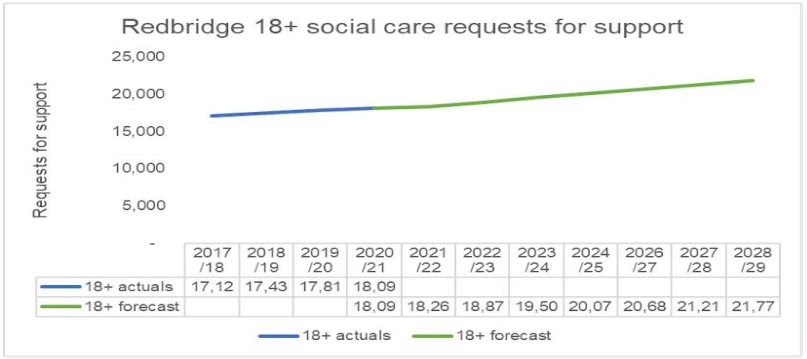


Demand projections for social care

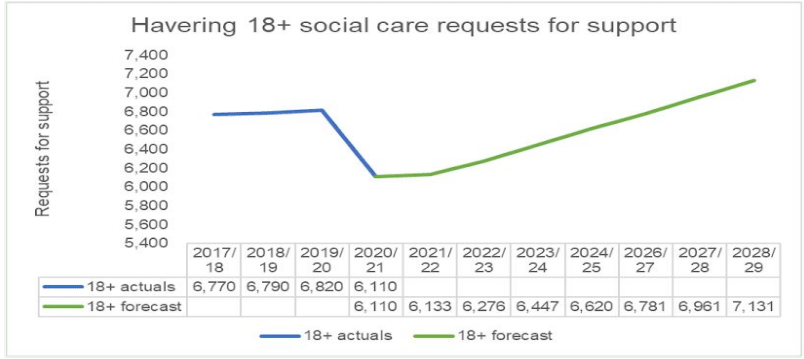
- This forecast is based on social care social care data showing number of requests for support received from new clients aged 18+.
- Approach to high level model:
  - Demographic growth assumption based on GLA housing led population projection (2021-based identified capacity scenario)
  - Non-demographic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



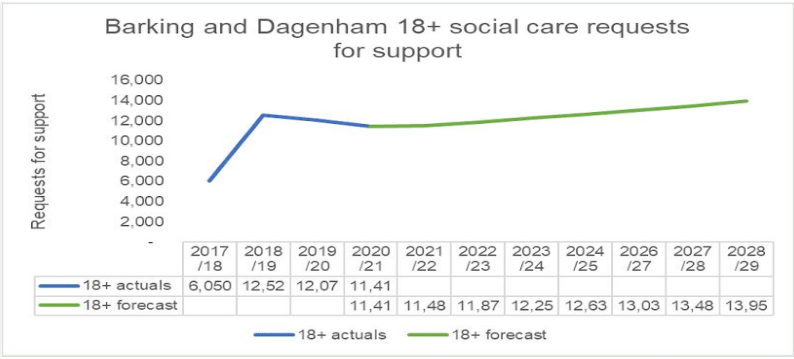
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	3,925	3,960	3,575	5,485							
18+ forecast				5,485	5,618	5,834	6,054	6,267	6,469	6,680	6,914



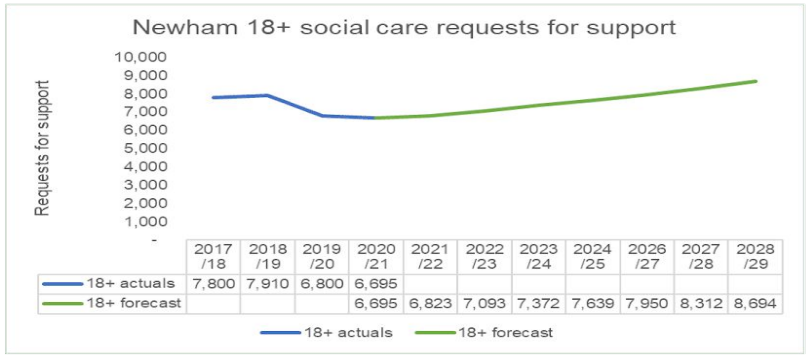
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	17,12	17,43	17,81	18,09							
18+ forecast				18,09	18,26	18,87	19,50	20,07	20,68	21,21	21,77



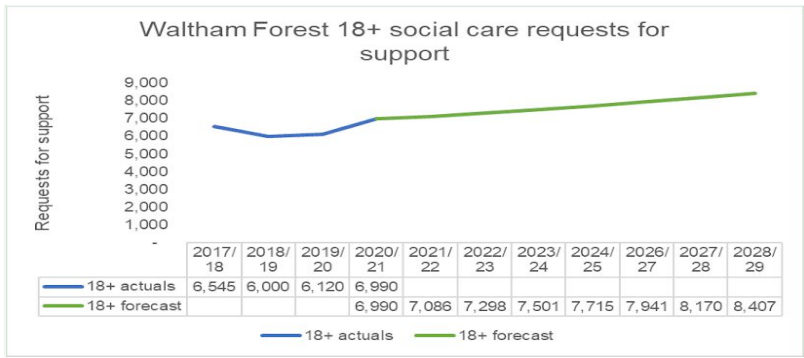
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	6,770	6,790	6,820	6,110							
18+ forecast				6,110	6,133	6,276	6,447	6,620	6,781	6,961	7,131



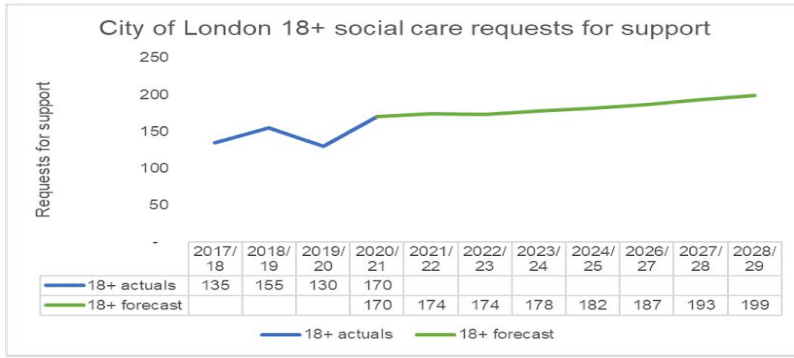
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	6,050	12,52	12,07	11,41							
18+ forecast				11,41	11,48	11,87	12,25	12,63	13,03	13,48	13,95



	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	7,800	7,910	6,800	6,695							
18+ forecast				6,695	6,823	7,093	7,372	7,639	7,950	8,312	8,694



	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	6,545	6,000	6,120	6,990							
18+ forecast				6,990	7,086	7,298	7,501	7,715	7,941	8,170	8,407



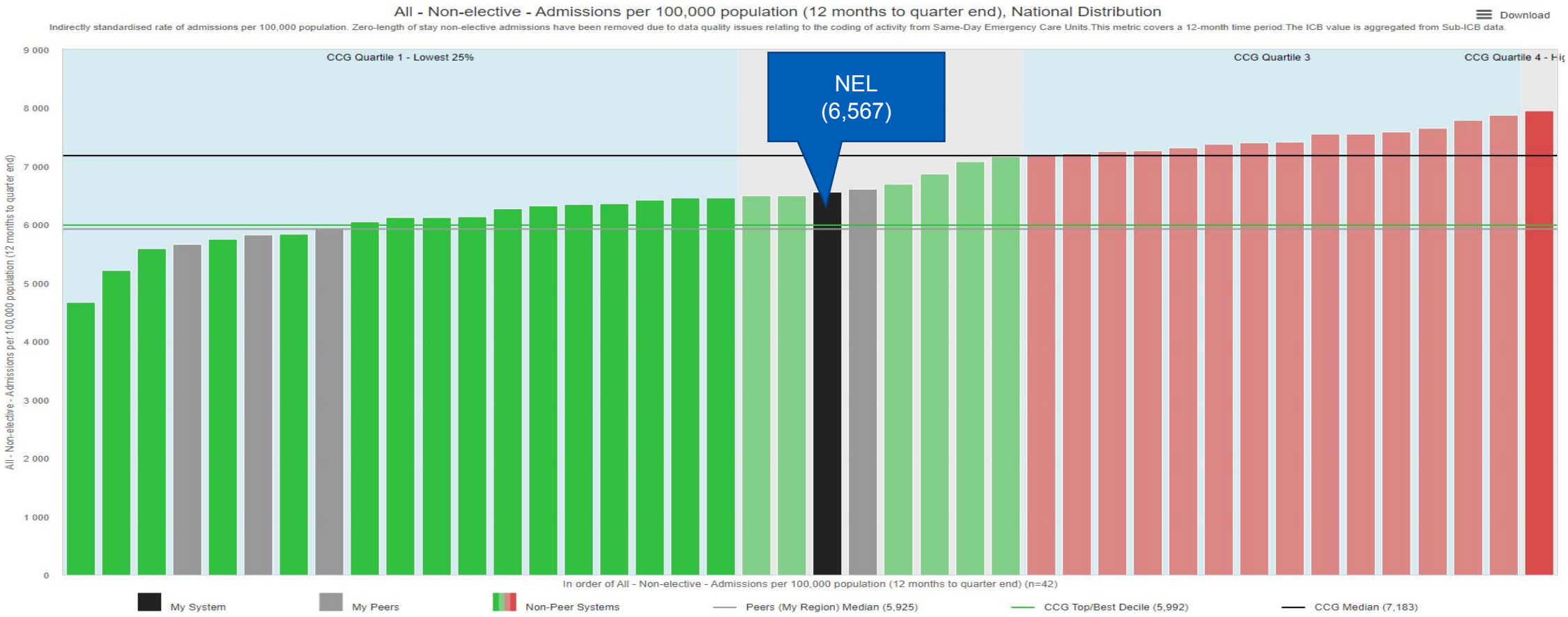
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2026/27	2027/28	2028/29
18+ actuals	135	155	130	170							
18+ forecast				170	174	174	178	182	187	193	199

Annex 9B - Benchmarking

Urgent and Emergency care benchmarking

Non-elective admission rates

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

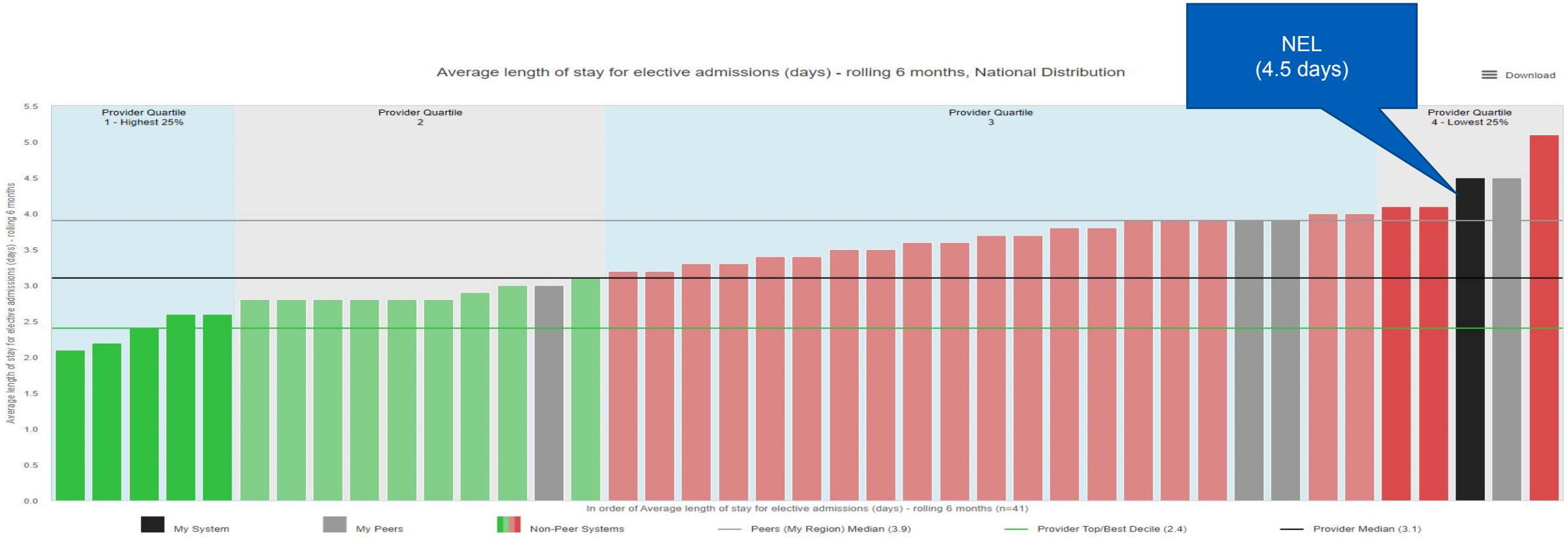


Data is from 'Model Health System' and covers a 12-month period, ending Q2 2022/23.

Elective care benchmarking

LOS for elective admissions

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



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

Annex 9C - improvement opportunities data

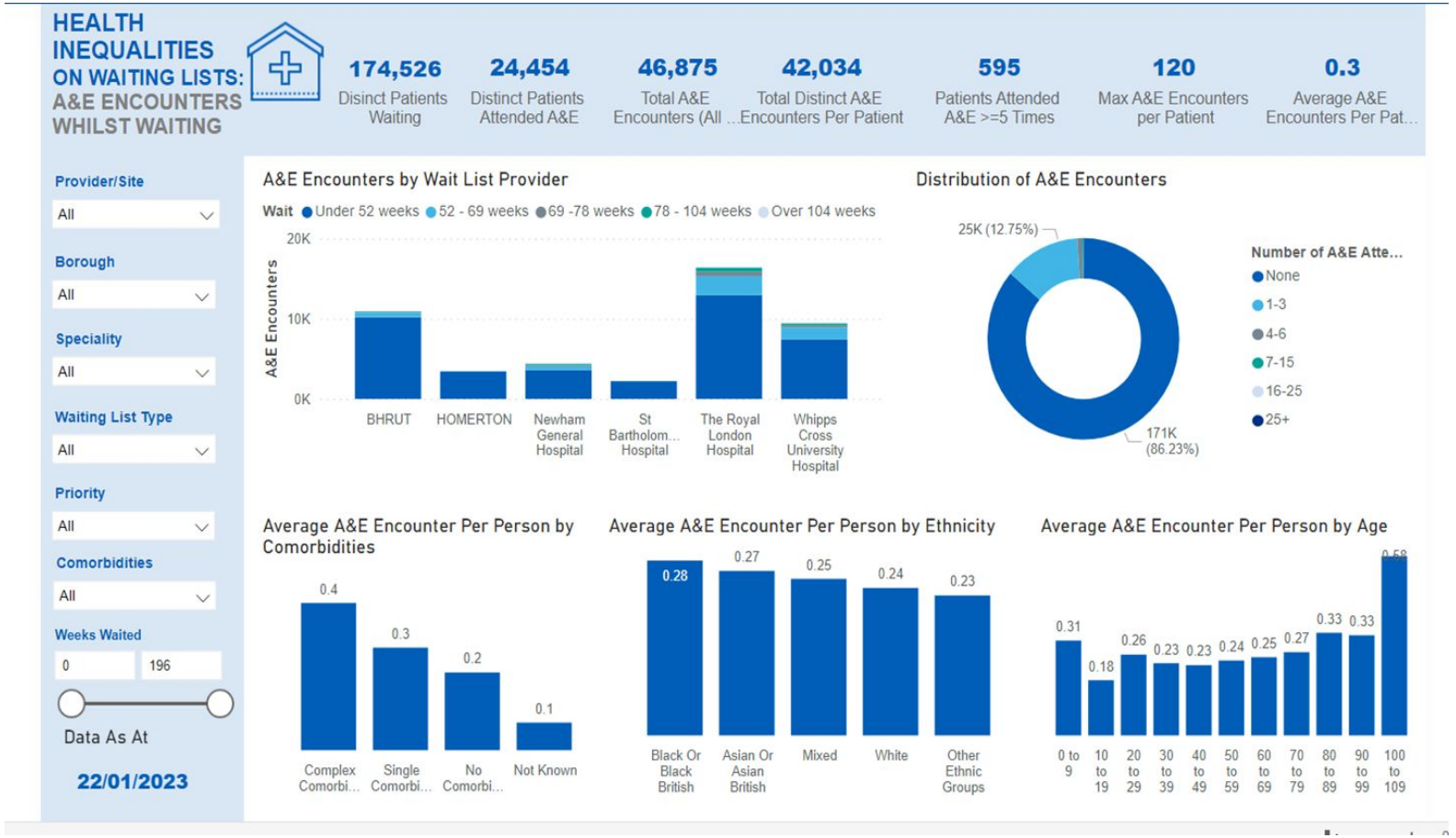
UEC – opportunities for improvement

Waiting list management

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

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

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



UEC – opportunities for improvement

Avoidable admissions

Emergency admissions for conditions not usually requiring hospital treatment

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

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

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

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

Unplanned hospitalisations for chronic ambulatory care sensitive conditions

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

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

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

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

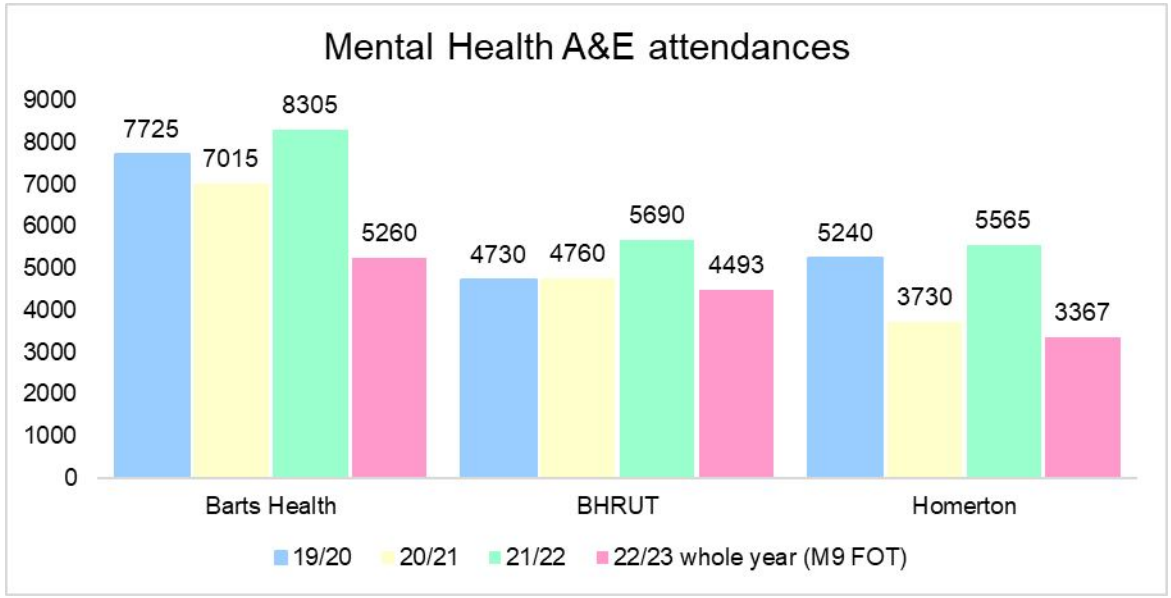
Among the 273 NEL practices included as operational during the period of this analysis, 46 practices have a rate that is identified as a (statistically significant) high outlier compared to rates at all NEL practices and accounting for the underlying practice populations

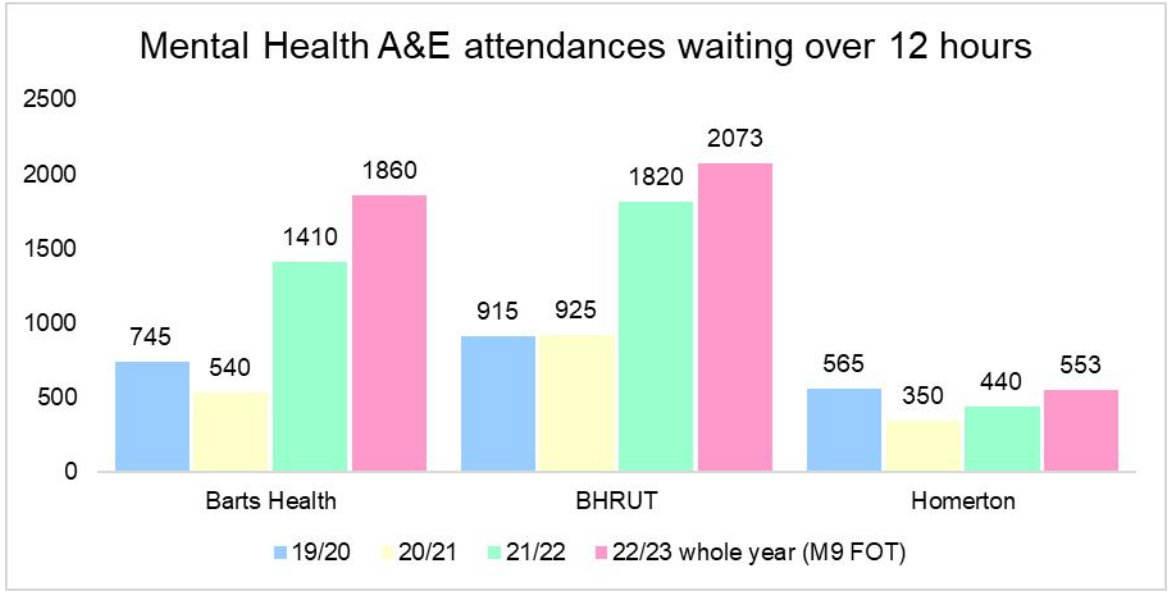
UEC – opportunities for improvement

Mental health patients in A&E

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

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





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

The size of children's social care in East London

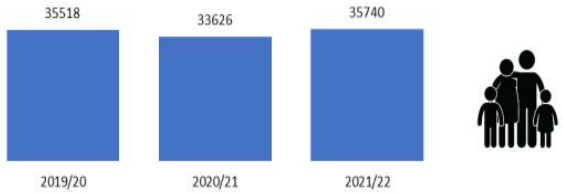
Children social care numbers

1st April 2021-31st March 2022

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

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

Children in need 3-year trend



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

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

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

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

Community service mapping – Unplanned / planned

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

Community service mapping – Adult therapies, equipment & coordination

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

Community Service Mapping – specialist services

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

Annex 9D - transformation portfolio

The transformation portfolio:

core elements of high-quality care and a sustainable system

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

The transformation portfolio:

core elements of high-quality care and a sustainable system

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

The transformation portfolio:

additional local strategic priorities

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

The transformation portfolio:

additional local strategic priorities

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

The transformation portfolio:

additional local strategic priorities

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

The transformation portfolio:

further local priorities

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

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