North East London Health & Care Partnership

# North East London (NEL) Joint Forward Plan - Refresh

July 2024

# Foreword

Welcome to our refreshed five-year Joint Forward Plan.

We are proud of the achievements and progress we have made over the last year in addressing the health needs of the NEL population and supporting our health and care workforce. None of this would have been possible without our strong partnerships, aligned and enabled through our Integrated Care Strategy, which are rooted in innovation and a passion for improvement. We know that we have lots more to do, as set out in this updated Joint Forward Plan (JFP).

The last couple of years have been extremely challenging for our population, the NHS and our partners. Local people are continuing to be impacted by the consequences of the Covid-19 pandemic and the ongoing cost of living crisis which is contributing to increased demand on health and care services. These challenges are set to grow as unprecedented population growth continues to redefine our communities over the coming decades, and the health and care needs of local people continue to become more complex.

North east London is unique. We are 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. We are rich in history, culture and deep-rooted connections with strong and resilient communities. Despite this, local people experience significant health inequalities. We know that we have one of the fastest growing populations in England, and that we have pockets of deprivation across our patch. In addition to our financial challenges, we have a high demand for urgent and emergency care, and we continue to have long waiting lists for planned care.

Despite the challenges, we have some great assets in north east London, including our workforce, our voluntary and community sector partners, our dynamic research and innovation sector, and most importantly our local people, who we want to continue to listen and learn from.

These present us with opportunities to do things differently, moving from treatment to prevention, and working collaboratively and improving productivity to address the needs of the population. In practice this means, for example, improving access to primary care, making more services available in the community and enabling our health and care workforce to work together on what matters most to our local people.

Each of our transformation programmes, as explained in our JFP, outlines how they are transforming services and what the impact will be for our residents. We will reduce waiting times and unwarranted variation in access where that exists, reduce delayed discharges, expand virtual wards beds, and we will make integrated services available in our neighbourhoods.

We will do this by working together, and collaborating across organisational boundaries in our Places and across the north east London, to give our local people the same opportunity to be healthy.

This is an ambitious plan, and we look forward to continued collaboration between health and care partners in north east London to successfully deliver our Joint Forward Plan. We will continue to evolve as a system and codesign solutions with our local authorities, voluntary and community organisations and our local people. The learning from the last couple of years has shown us that we can achieve great things together for our population.

**Marie Gabriel CBE**
Chair of North East London ICB

**Zina Etheridge**
Chief Executive Officer of North East London ICB

# 1. Introduction

# Introduction

- This Joint Forward Plan builds on our initial plan published in 2023/24, refreshing and updating the challenges that we face as a system as well as the assets of our partnership in meeting the health and care needs of our local people.
- We know that the current model of health and care provision in north east London (NEL) needs to adapt and improve to meet the needs of our growing and changing population. In this plan we describe the substantial portfolio of transformation programmes through which we will deliver these changes, alongside the work of our seven Place-based Partnerships aligning around our six strategic cross-cutting themes.
- 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 our work to strengthen key enablers including our estate and digital infrastructure as well as financial sustainability.
- Our Joint Forward Plan will be refreshed annually to reflect that, as a partnership, we will need to adapt our plans in response to our collective learning and the evolving nature of the challenges we face together. We will work with local people, partners and stakeholders to update and improve the plan to ensure it stays relevant and useful to partners across the system. Local Health and Wellbeing Boards are working with our Place-based Partnerships to ensure key aspects of locally developed joint strategic needs assessments (JSNAs) and joint local health & wellbeing strategies (JLHWSs) are considered when developing our plans.

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

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

- **Poverty and deprivation** – which is more severe and widely spread compared with other parts of London and England, and further exacerbated by the pandemic and cost of living crisis which have disproportionately impacted communities in north east London
- **Population growth** – significantly greater compared with London and England and concentrated in some of our most deprived and ‘underserved’ areas, alongside a rapidly changing demographic profile in several of our places
- **Inadequate investment** available for the growth needed in both clinical and care capacity and for innovation as well as 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 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 agreed to focus together on four priorities as a system. There are a range of other areas that we will continue to collaborate on, but we will ensure there is a particular focus on our system priorities. We have been working with partners to consider how all parts of our system can support improvements in quality and outcomes and reduce health inequalities in these areas.

We recognise that a well-functioning system that is able to meet the challenges of today and future years is built on strong foundations. Our strategy sets out our ambition to transform our enabling infrastructure to support better outcomes and secure a more sustainable system. This includes 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 our strategy and this Joint Forward Plan build upon the principles agreed by London integrated care boards (ICBs) with the Mayor of London.

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

| Improve quality and outcomes | Deepen collaboration | Create value | Secure greater equity |
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**6 Crosscutting Themes underpinning our new ICS approach**

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

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

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

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

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

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

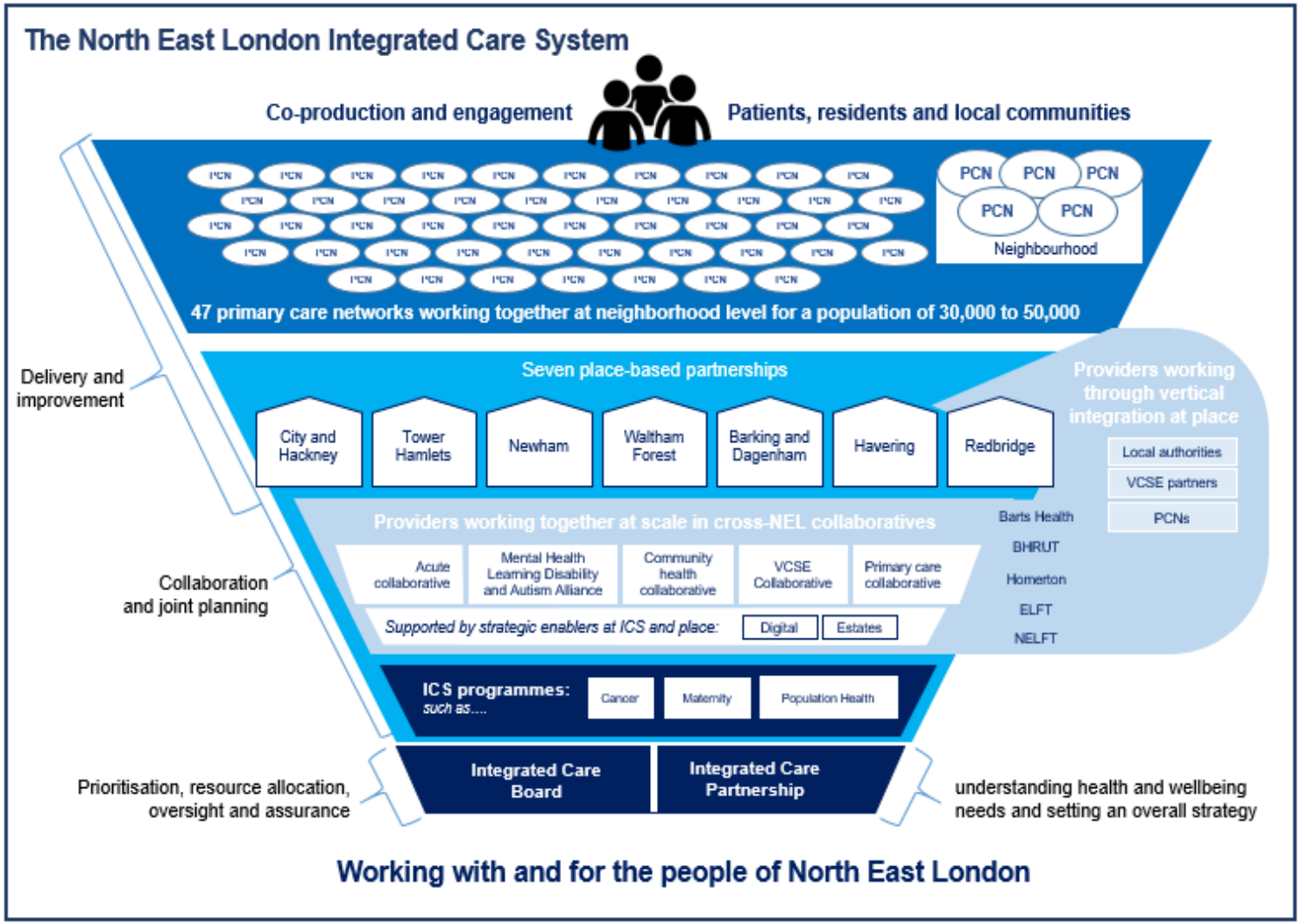
Each of our partners have positive impacts on the people of north east London – some providing care, others involved in planning services and others impacting on wider determinants of health and care such as housing and education. As we deepen our collaboration and strengthen integrated ways of working, we will seek to deliver greater impact for our population.

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

With hundreds of health and care organisations serving more than two million local people, we want to build on the strengths of individual partners and promote integration, ensuring that decisions are made at the most appropriate level.

Groups of partners coming together within both place-based partnerships and provider collaboratives are crucial building blocks for how we will deliver. We will reflect on the London Region review of provider collaboratives and incorporate any learning into the development of our NEL collaboratives.

Successful delivery of this plan is a joint effort between health and care partners across north east London, as demonstrated by the joint leadership within many of our boards and committees.



# 2. Our unique population

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

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

## Rich diversity

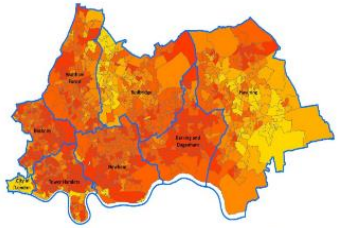
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from global majority backgrounds.

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

## Young, densely populated and growing rapidly

There are currently just over two million residents in NEL and an additional 206,226 will be living here by 2041 (ONS).

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



## Poverty, deprivation and the wider determinants of health

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

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

## Stark health inequalities

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

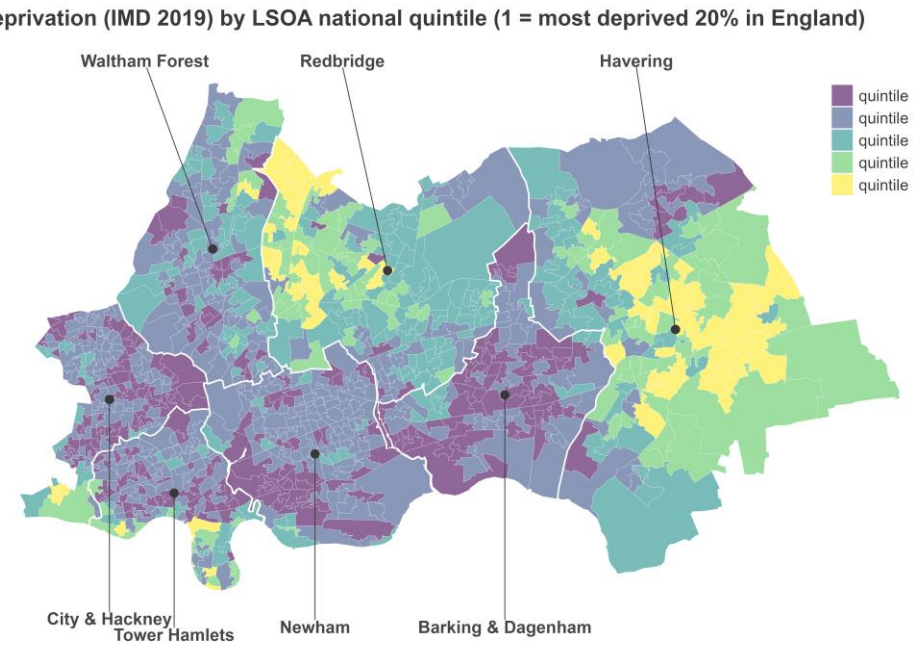
Our population has been disproportionately impacted by the pandemic and recent cost of living increase.

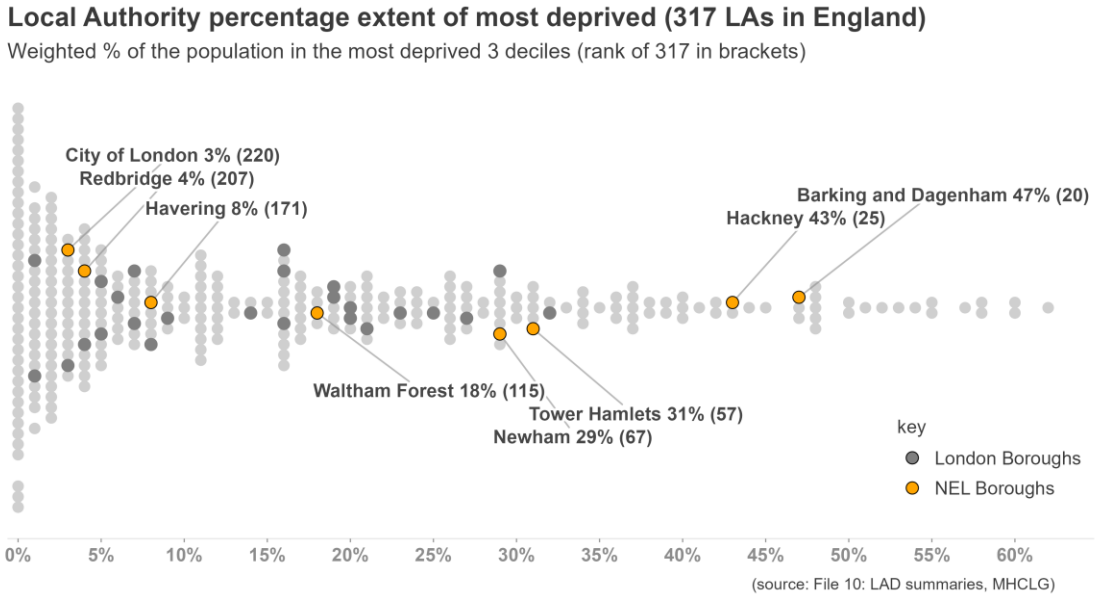
# Poverty, deprivation and ethnicity are key factors affecting the health of our population and driving inequalities

Large proportions of our population live in some of the most deprived areas nationally. Deprivation is typically measured at small-neighbourhood level (LSOA). By this measure, NEL has four of the top six most deprived Borough populations in London, and some of the highest in the country (chart below).

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

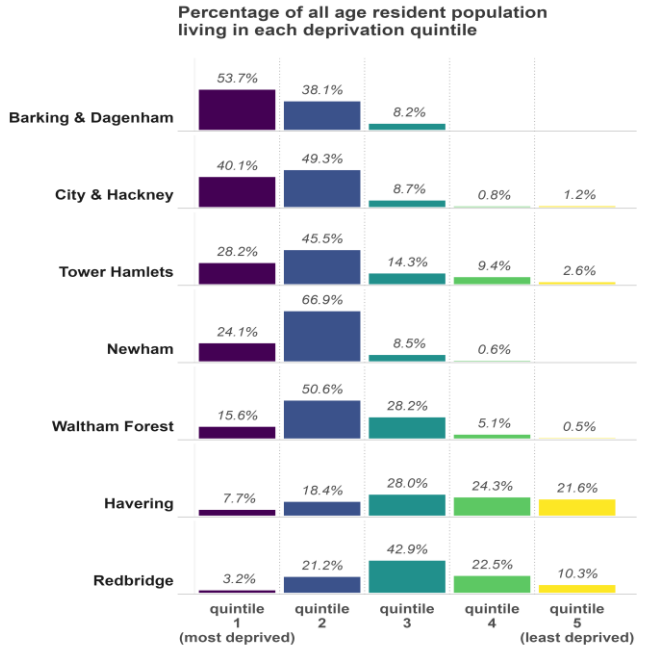
But even these small-area measures conceal severe hidden inequality. Recent research shows that NEL, and particularly Tower Hamlets, has a very high level of inequality within these small-neighbourhood areas. Affluent populations of one ethnic group live alongside very deprived populations of another ethnic group. This may pull up the 'average' deprivation metrics, but this masks large numbers of people who are still affected by severe poverty and deprivation.




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 (LTCs) than the wealthiest along with 30% higher severity of disease
- people of South Asian ethnic origin are at greater risk of developing Type 2 Diabetes and cardiovascular disease, and
- people with an African or Caribbean family background are at greater risk of sickle cell disease.



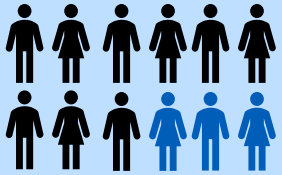
# To meet the needs of our population we need a much greater focus on prevention, addressing unmet need and tackling health inequalities

### Poverty

Five NEL boroughs have the highest proportion of children living in low income families in London and since 2014 the proportion of children living in low income families is increasing faster in NEL than the England average.

### Homelessness and vulnerable housing

NEL has higher numbers of vulnerably housed and homeless people, including refugees and asylum seekers, and those in overcrowded and temporary accommodation compared to both London and England.



7 out of 10 of recent* deaths of people under 75 were found to be **avoidable.** This equates to on average **3,231 deaths per year** being avoidable in NEL.

NEL has high rates of avoidable mortality compared to London and England.
**Barking & Dagenham** has the **highest avoidable mortality** rate and **lowest healthy life expectancy** in all of London**.**

**Cancer and cardiovascular disease** accounted for **50%** of all avoidable deaths.
**Lung cancer** was the main contributor to avoidable deaths by cancer.
**Ischaemic heart disease** was the main contributor to avoidable deaths from cardiovascular disease.

There is a **strong relationship between higher levels of deprivation and higher rates of avoidable mortality in under 75s**. This is most stark for cardiovascular disease.

### Obesity

**1 in 10 children in reception** and **1 in 3 children in year 6** had obesity in 2022/2023. This is higher than the London and England average.

Around 1 in 10 adults in NEL have obesity, which is higher than the London average. **Barking and Dagenham has the highest adult obesity rate in London.**

### Low vaccination uptake

The NEL average rate of uptake for all infant and early years vaccinations in lower than both the London and the England rates.

### There is indication of unmet need across our communities

For many conditions there are low recorded prevalence rates, while at the same time most NEL places have a higher Standardised Mortality Ratio for those under 75 (SMR<75) – a measure of premature deaths in a population – compared to the England average. Whilst some of this may be due to the age profile of our population, there may be significant unmet health and care need in our communities that is not being identified, or effectively met, by our current services.

### Tobacco

Smoking is a leading cause of health inequalities. **1 in 20 women in NEL smokes at time of delivery**, and adult smoking prevalence in most NEL boroughs is higher than the England average.

***Avoidable death definition:** under 75 deaths that are preventable through public health intervention, or treatable via effective healthcare. Data related to deaths over 5 years 2018 to 2022, including COVID-19 deaths. Source: ONS mortality data (NEL residents)

# Population growth in NEL is set to continue which will increase the demand for local health and care services

North east London had the fastest growing population in the country over the last 20 years (2001 – 2021) and this rapid population growth for NEL is forecast to continue, driven by population demographics and local housing plans.

The office for national statistics (ONS) forecast on which NHS allocations are based indicates continued high growth in NEL, however, the Greater London Authority (GLA) population projections which also take account of local housing plans point to growth being significantly higher than the ONS forecast. The implications of this are a significant lag in funding for NEL to match the rate of growth.

The ONS forecasts a growth in NEL population of **206,226** between 2021 and 2041.

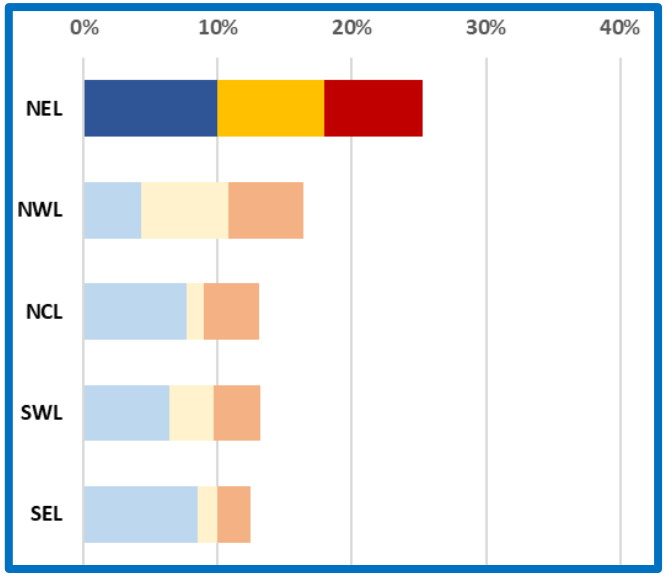
The GLA has produced planning scenarios indicating significantly increased growth in NEL:

**Past Delivery Scenario**:
Housing growth at historic delivery rates
Projecting a population increase of **308,576** by 2041

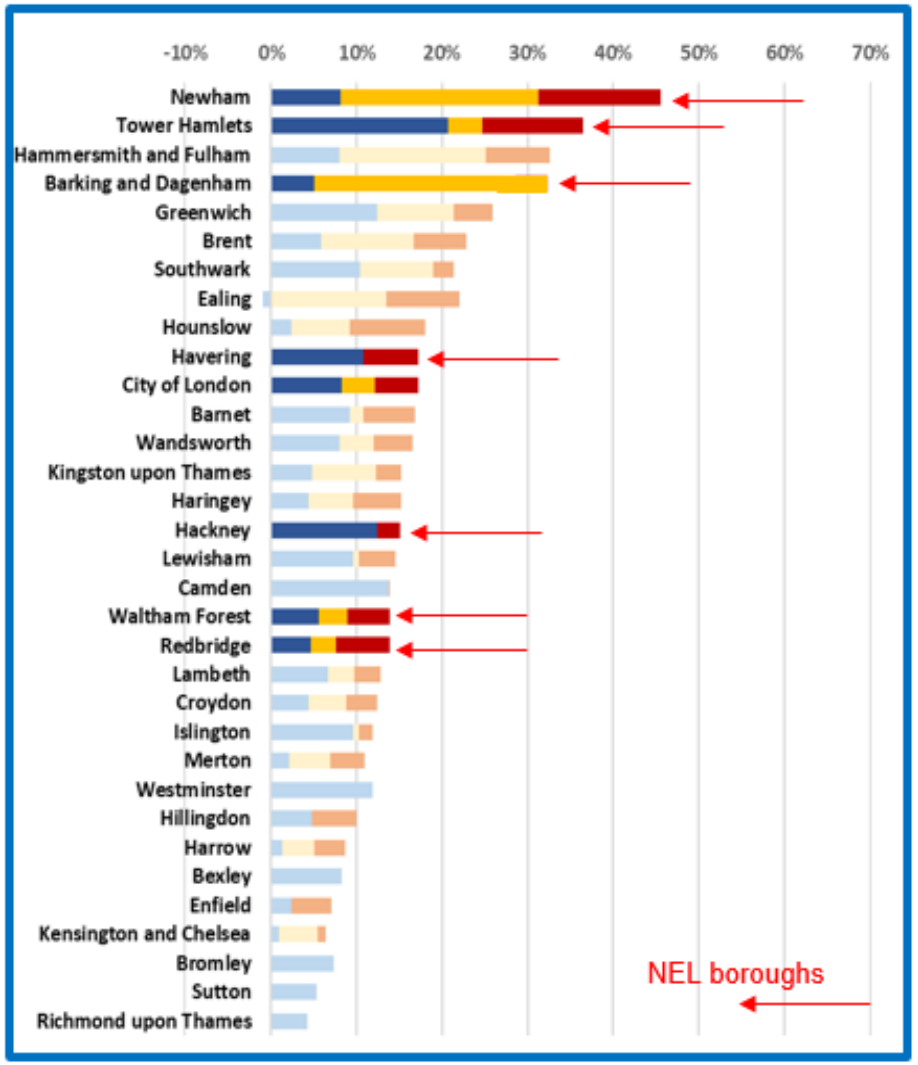
**Identified Capacity Scenario**:
Housing growth in line with identified development sites
Projecting a population increase of **331,432** by 2041

**Housing Targets Scenario**:
Housing growth in line with government housing targets
Projecting a population increase of **379,757** by 2041

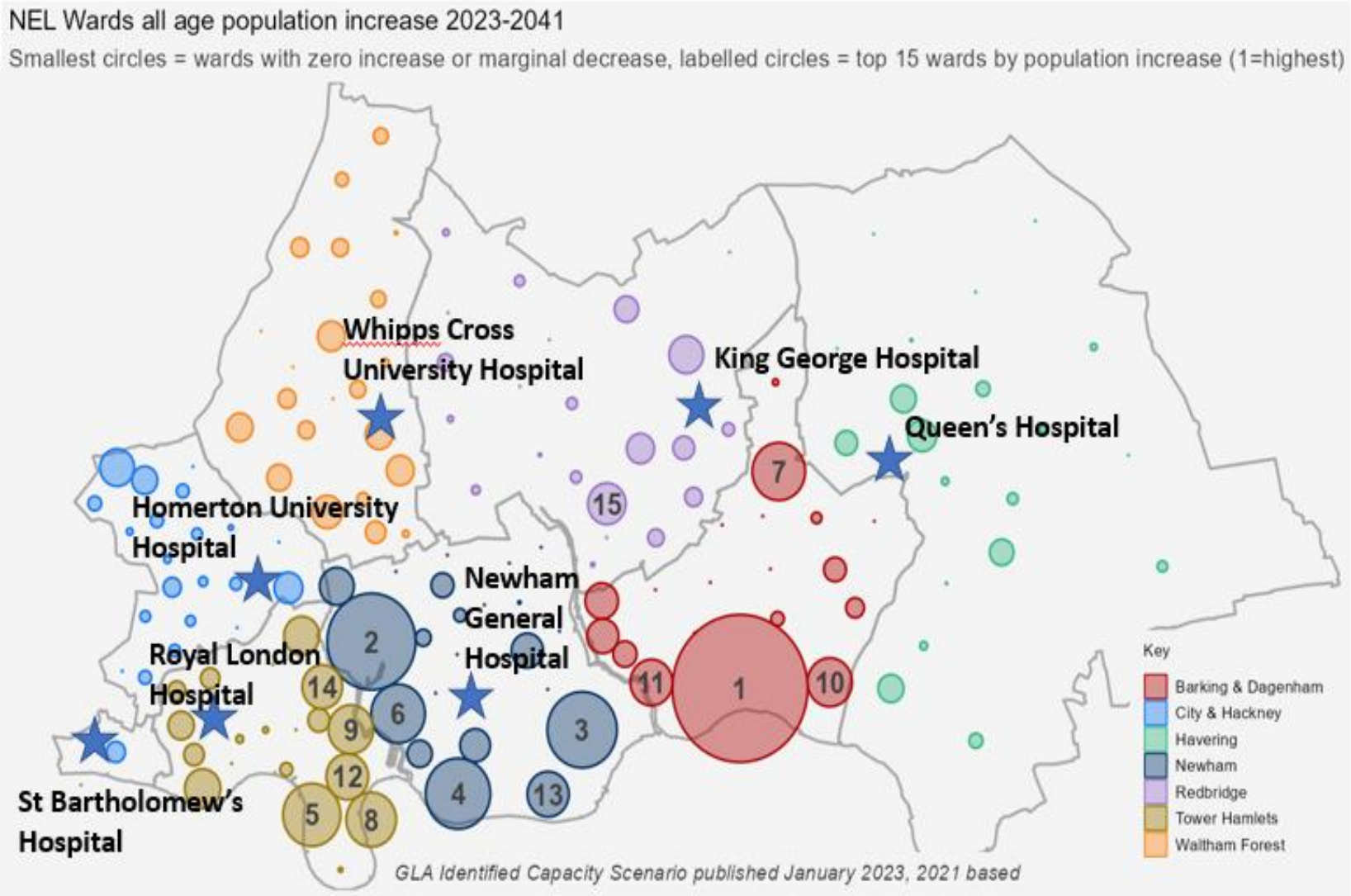
**GLA housing-led population projections by ICS 2021-2041**




**GLA housing-led population projections by LA 2021-2041**



# Forecasted growth will be unevenly distributed across NEL, particularly across our most deprived and currently underserved places




Our **rapidly growing** population experiences some of the worst **poverty and deprivation** in the country, with **poorer outcomes** across many indicators and evidence of **significant unmet need.**

Furthermore, our **hotspots of population growth** in NEL are focused in some of the most deprived parts of our geography including London Borough (LB) Barking & Dagenham where over half of the current population (54%) live in the most deprived quintile nationally and LB Newham where a quarter of the population live in the most deprived areas nationally (24%).

The place with highest projected growth in north east London (LB Barking & Dagenham) currently **lacks the essential infrastructure for health and care**. There is insufficient primary care capacity for existing growth in Barking and Dagenham and no acute provision whatsoever within the borough. This will mean service provision will likely need to adapt to new demand as uneven dispersed growth occurs.

Trends in growth across NEL have typically been in young people and adults – whereas future growth will be across adults and older people contributing to a forecast 72% increase in outpatient and inpatient activity over the next 19 years.

# 3. Our assets

# We have significant assets to draw on

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

**Our assets**

- **The people of north east London** – bring vibrancy and diversity, form the bedrock of our partnership, participating in our decisions and co-producing our work. They are also our workforce, provide many 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 our own research and pilots, working with higher education and academic partners to evidence what works for our diverse communities/groups. We want to build on this work 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 as well as innovating, using data and evidence to continually improve. Strong clinical leadership is essential to lead professional communities, support and inform difficult resourcing decisions as well as help set system priorities. Our integrated care system (ICS) will benefit from integrated and diverse leadership including senior leaders, front line staff, the community and voluntary sector, local people and those with lived experience.

- **Financial resources** – we spend over £4bn on health services in NEL. Across our public sector partners including local authorities, schools and the police an additional £3bn is invested. We want to work together to ensure our collective use of resources are delivering best value for our population, improving outcomes and reducing inequalities in a sustainable way.

- **Primary care** - is the bedrock of our health system. We will support primary care partners to create a multi-disciplinary workforce, able to be both responsive and proactive in meeting the needs of their local population and focused on improving access, quality and outcomes for local people in an integrated way.

- **Collaboration** – we have historical collaborations between organisations that can be built on as our system matures further. For example, long established cooperation and collaboration has existed within the Barking & Dagenham, Havering and Redbridge (BHR) footprint as well as in City & Hackney which has adopted a collaborative commissioning approach. An interim NEL ICS Procurement Collaborative has been established across multiple providers working on clinical consumables, data & systems and transactional processing. Linked to this is a Social Value workstream that supports embedding social value into procurement.

# Our health and care workforce is a great asset to us

Our ICS People and Culture Strategy sets out our vision for a joined up ‘One Workforce for NEL Health and Social Care’ which will work across organisational boundaries, collaborating and learning from each other to deliver consistent best practice. We will increase support for our current and potential workforce through the implementation of inclusive retention and health and well-being strategies, and creating innovative, flexible and redesigned heath and care careers.

We want to contribute to the social and economic development of our local population through upskilling and employing under-represented groups from our local people; creating innovative new roles; values-based recruitment; and locally-tailored, inclusive supply and attraction strategies in collaboration with education providers.

Our workforce is critical to transforming and delivering the new models of care we will need to meet the needs of our growing population. We will ensure that our staff have access to the right support to develop the skills needed to deliver the health and care services of the future and adapt to new ways of working. AI and digitalisation will play a major role in determining our workforce needs over the next ten years. Aligned to the Long Term Workforce Plan, we are working with our Higher Education institutes and health and care providers to increase trainees and placements for students to ensure that we have pipeline and pathway from education to employment in NEL. We will utilise apprenticeships to promote inclusion and provide opportunities for our population develop health and care careers in NEL.

The newly established NEL Health Equity Academy has an ambition to support all people and organisations working in health and care in NEL to be equipped with the knowledge, skills and confidence to reduce health inequalities for the benefit of local people. One of the main ways in which we will do this is by delivering and coordinating education and training to increase understanding of and develop the skills needed to tackle health inequalities. This includes providing access to training on a range of topics including leadership for health equity, and skills-related training such as evaluation. We are developing a locally focused health equity curriculum for primary care, and developing fellowship offers for different sectors.

We will work together to describe our system values and behaviours which will support greater integration and collaboration across teams, organisations and sectors.

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

Our workforce includes:

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

# We will provide better outcomes for our local people by working together across the voluntary and community sector, social care and health

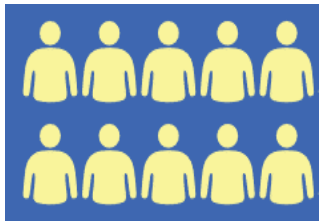
**Voluntary, Community, and Social Enterprise (VCSE) organisations** are essential to the planning of care and to supporting a greater shift towards prevention and self-care. They work closely with local communities and are our strategic partners in system transformation, innovation and integration. In NEL we benefit from an active VCSE Collaborative which aims to create the enabling infrastructure, support sustainability of our rich and diverse VCSE in NEL and ensure the contribution of the VCSE is valued equally. Our VCSE partners also play a key role within our Place-based Partnerships in finding solutions to local people's health and care needs, especially in its focus on wider determinants of health.

**Social care plays a crucial role in improving the overall health and well-being of local people** including those who are service users and patients in north east London. Social care promotes people's wellbeing and supports them to live independently, staying well and safe. It includes the provision of support to individuals who have difficulty carrying out their day-to-day activities due to physical, mental, or social limitations. Through this, social care services help to prevent hospital admissions and reduce the length of hospital stays. This is particularly important for elderly patients and those with chronic conditions who may require long-term social care support to maintain their independence and quality of life.

**In north east London, we have a high percentage (75%) of elective patients discharged to a care home that have a length of stay that is over 20 days, which is considered a long stay in hospital.** This compares to 33% for the median London ICS. We want to work with system partners in social care, health and the voluntary and community sector to learn from other ICSs and identify ways to shorten length of stay and improving quality of life for those affected.

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

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



There are **5,470 registered 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. This includes organisations committed to 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.

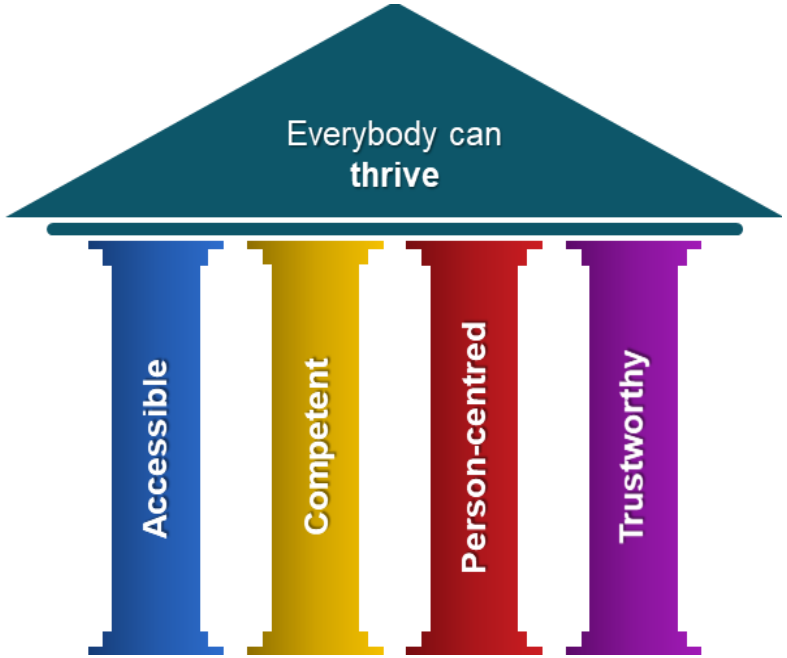
# Listening and engaging with our residents across NEL about their health, care and wellbeing is essential to improving our services

We are committed to our '*Working with people and communities*' strategy, working with local people and those who use our services to identify priorities and the criteria against which we will monitor and evaluate our impact.

Over summer 2023 we engaged with around 2000 people in our 'Big Conversation' through an online survey, face to face community events and targeted focus groups including Turkish mothers in Hackney, South Asian men in Newham and Tower Hamlets, Black African and Caribbean men in Hackney, older people in the City of London, patients with Long Covid in Hackney, men in Barking and Dagenham, Deaf BSL users in Redbridge, young people in Barking and Dagenham and Pakistani women in Waltham Forest.

What we've heard people would like to see more of and what they believe makes a difference can be summarised as: **Good care.**

## What does good care look like?




We will use these pillars to help us to understand whether we are making a difference to health and wellbeing outcomes.

## What does good care mean?

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| Good Care is **Trustworthy:**<br>• Listening to patients, honest and empathetic care<br>• Follow-on, ongoing appointments<br>• Reassurance, supported self-care<br>• No gatekeeping<br>• Anticipative, not just reactive care<br>• Communication<br>• Accountable care | Good Care is **Accessible:**<br>• Availability of appointments<br>• Affordable care<br>• Improved booking systems<br>• Adequate staffing<br>• Convenient opening times<br>• Accessibility – disabled patients<br>• Convenient locations |
| Good Care is **Person-centred:**<br>• Patient involvement in treatment options<br>• Patients having a choice about where/how they access care<br>• Shared medical records, consistency of care<br>• Holistic approach to care<br>• Continuity of care<br>• Health and care services working with each other<br>• Collaboration beyond health and care | Good Care is **Competent:**<br>• High quality of care<br>• Adequate staffing – skills and numbers<br>• Services that know/understand specific conditions /medical needs<br>• Services that know/understand patients' cultural and social needs<br>• Evidence-based medicine<br>• Prompt, efficient diagnosis process<br>• Adequate funding, resourcing, facilities |

We will continue to shape and design our programmes of work based on the insight from the big conversation and other engagement with our local people.

# 4. Our challenges and opportunities

# The key challenges facing our health and care services

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

Two of the most pressing and visible challenges our system faces today 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 challenges reflect pressures in other parts of the system and, in turn, impact other services.

The wider determinants of health are also a key issue, in particular rising levels of unemployment which during the pandemic rose to a peak of 79,600 before falling to 65,900. Currently 22% or 321,000 of our 16-64 population is classed as economically inactive. We have established work well programmes in partnership with all boroughs and across government departments to support people in to work.

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. 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 the 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 us to recruit and retain our workforce. This is a key challenge, with high numbers of vacancies across health and care roles in NEL, and an ageing population and high turnover of staff, and increasing numbers of staff reporting burnout, particularly since the Covid-19 pandemic.

***The following slides describe these core challenges and potential opportunities in more detail. Where possible we have taken a population health approach, considering how our population uses the many different parts of our health and care system and why. More work is required to build this fuller picture (including through a linked dataset), as well as develop our population health outcomes-based approach to planning, commissioning and resource allocation, which forms part of our development work as a system. This will inform our forthcoming strategic commissioning plan.***

# We have high demand for people requiring urgent and emergency care

| *Key Challenges* | *Detail* |
| --- | --- |
| Nationally demand for urgent and emergency care (UEC) continues to grow post Covid-19. Across NEL we have planned for a 2% growth in UEC demand | • Patients are presenting with more complex conditions.<br>• Since the pandemic the increase in complexity and acuity is having knock-on impacts across the urgent and emergency care pathway, this includes ambulance call-outs, ambulance handovers, accident & emergency (A&E) 4 hour performance and length of stays |
| Longer term trends point to an increasing need for health and care | Outside of the immediate challenges presented post pandemic we are facing a growth in demand due to:<br>• population growth,<br>• an ageing population, and;<br>• greater numbers of people living with long term conditions. |
| Occupancy levels for our general and acute hospitals continues to be a challenge – especially during the winter | • High bed occupancy is a key driver for increased pressure across urgent and emergency care services. When our hospitals have high occupancy levels it is harder to identify beds for patients that need to be admitted.<br>• Higher occupancy coupled with longer lengths of stay also results in challenges in discharging patients back into their own homes or their communities. Across NEL there is also the challenge in reducing the amount of hospital beds that are occupied at any one time by patients that are medically fit for discharge. |
| Increasing demand and length of stay on emergency mental health services | • Long waits for people with mental health needs in A&E are increasing. There continues to be significant demand from mental health attendances in A&E, with hospitals seeing an increase in the complexity and acuity of patients which leads to increased wait times and length of stay. Initiatives continue to be implemented to reduce these waits through delivery of mental health inpatient and community services |

# We have a large backlog of people waiting for planned care

| *Key Challenges* | *Detail* |
| --- | --- |
| Demand for elective care continues to grow, adding to the significant existing backlog | • Demand for planned care is expected to continue growing between 2024/25 and 2027/28.<br>• Referral demand (all sources) in 23/24 has been higher than the prior year, although this growth is not equitably split across NEL<br>• As at January 2024, there are around 215,000 people waiting for elective care |
| Activity levels have continued to vary week on week. We have seen some improvement in our waiting list position in the latter part of the year, but this remains higher than last year | • Activity levels vary throughout the year, with industrial action a key factor in 2023/24.<br>• Our waiting list position increased from 205k to 215k (April 23 to Jan 24) with the majority of this growth occurring between April to August. Since then the waiting list has been on a reducing trajectory |
| There are other factors impacting the delivery of elective care | • Recent and potentially further industrial (strike) action has meant that many appointments and treatment pathways have been impacted. Nationally this has led to reductions in the national elective recovery activity target. |
| Tackling the elective backlog is a long-term goal and will require continuous improvements to be made | • Reducing the elective backlog will require a joint effort across all our partner organisations in order to tackle the challenge. As we evolve as a system partnership we will be able to explore new ways of working between providers that will better utilise our collective elective care capacity. |
| There may be opportunities for improvements in elective care, particularly around length of stay (LoS) | • A benchmarking analysis of NEL against other London ICSs and England, indicated we have higher median LoS for elective admissions. Understanding these differences and adopting best practice from other ICSs may contribute to improvements. |

# We need to expand and improve primary care, including improving the way care is coordinated

- Over the year to September 2023, booked general practice appointments across NEL increased by about a third to over 11 million appointments (two thirds face to face and 77% within a week). NEL is on track to meet the operating plan trajectory of 1 million appointments by March 2024, this is a 3% increase of appointments on the previous year, taking population growth into account.

- 47% of appointments were delivered by other professionals such as nurses and 44% of all appointments were seen on the same day as they were booked*. This figure includes both planned and reactive care. 57% of appointments were patient-initiated contacts, booked and seen on the same day.***

- There is wide variation in the number of delivered appointments or average clinical care encounters per week in NEL. For 2022/23 this ranged from 93.56 per 1000 (weighted registered) patients in Tower Hamlets, to 68.01 per 1000 (weighted registered) patients in Havering. The NEL average is 77.78 per 1000 (weighted registered) patients.**

- We are developing processes and technology to streamline patient access to the most appropriate type of appointment and advice, with clear signposting, for health care professionals and local people to ensure they are directed to the full range of services available at Practice and Place, in and out of general practice hours.

- Without substantial increases in primary care staffing the general practitioner (GP) to patient ratio will worsen as demand for primary care increases in line with projected population growth. There are pockets of workforce shortages with significant variation in approaches to training, education and recruitment. We are focusing upon initiatives to keep our staff, such as mentoring and portfolio careers, having developed SPIN (specialised Portfolio innovation) which is the basis for the national fellowship programme which we are offering to GPs and other professional groups.

- There are opportunities to build on our best practice to further develop integrated neighbourhood teams (INTs), based on multi-disciplinary teams (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.

**Primary Care Networks (PCNs)**

- Primary networks bring together GPs and other primary care professionals in small local areas to work together. They will work with new Integrated Neighbourhood Teams (INTs) to deliver joined up care based on individual and local needs.

- PCNs will be used to improve access, focus on preventative interventions, support personalised care, health education and harness wider community services through collaboration and navigation.

- PCNs will involve practices and federations, social care, community health services (CHS), mental health survives, pharmacy, care homes and links to hospitals and voluntary/community organisations.

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

# Develop and build upon our community care resources

- Community has had no additional national funding to support post covid-19 and since the pandemic demand has increased creating further challenge. In NEL, the community health spend is over £465m across a variety of services spanning primary care, four core provider trusts and over 66 other providers

- Our Community offers and models vary due to legacy commissioning and differing resource allocation, resulting in some fragmentation and inequity of provision. NEL ICS is doing work to better understand the impact this has on patient outcomes and variability of access across our 7 Places; exploring opportunities to tackle these issues and make changes. An example of this variance can be seen in pulmonary rehab services where we know there is difference in service inclusion criteria and staffing models. Waiting times also range between 35 and 172 days, with completion rates between 36% and 72% across our boroughs and services.

- Babies Children and Young people (BCYP) make up over 25% of our population and if we do not invest in their health and care it will significantly impact their life outcomes. This will also place further pressure across health, social care, education and criminal justice services. Our children and young people community service waiting lists are extremely pressured and the list is higher when compared to other systems. There are also a number of young people who are waiting in excess of 52 weeks for a first appointment with a community paediatrician.

- Our adult waiting lists have particular challenges including significant demands upon musculoskeletal (MSK) pathways, speech & language therapy (SALT), podiatry and dietetics.

- Community services are the key to supporting and enabling people to remain at home. They are also a key system enabler, supporting resilience and reducing pressures across UEC, ambulance services and social care but this opportunity can only be realised with a significant system resource shift from crisis and acute pathways to preventative, primary care and community pathways..

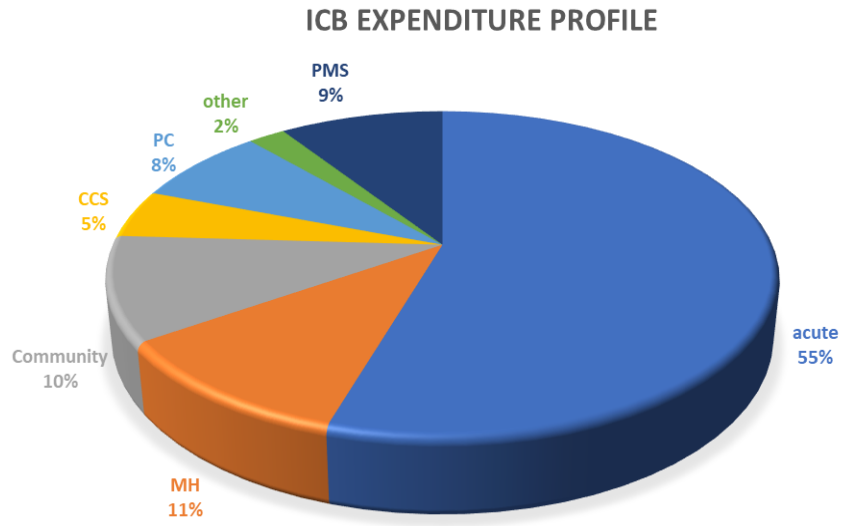
- There are opportunities to join up a range of initiatives across UEC, CHS and Place under our approach to virtual care, admission avoidance and supporting discharge (including virtual wards, rapid response, community beds, proactive care). This will involve looking at further integration and harmonising our core offer across a range of providers.

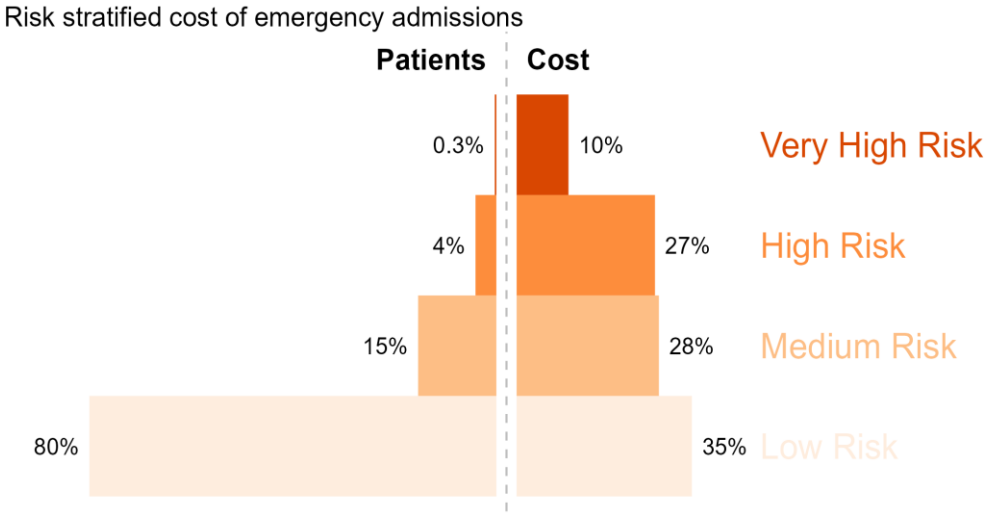
- Ensuring alignment of our emerging Integrated Neighbourhood teams and community offers for adults and babies, children and young people is a key element in supporting collaboration in relation to community nursing and social care

- The community collaborative are establishing numerous Improvement Networks using a partnership approach involving residents, carers and our clinicians to bring together best practice, drive change and implement innovation. This approach will ensure equitable and consistent pathways are delivered which are tailored to meet local population needs in a sustainable way.

# We need to move away from the current blend of care provision which is unaffordable

- The NEL system has a significant underlying financial deficit, held within the Trusts and the ICB, estimated to be in excess of £200m. This is driven by a variety of factors 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. The system is also looking at a range of further measures designed to improve the underlying run rate.
- In addition to a financial gap for the system overall, there are discrepancies between how much is spent (taking into account a needs-weighted population) across our Places, in particular with regard to the proportion spent on out of hospital care.
- The system received a capital budget of £95m in 2023/24, significantly less than other London ICSs (which receive between £130m-£233m) and comparable to systems with populations half the size of NEL*. This puts significant pressure on the system and its ability to transform services, as well as maintain quality estate. In 24/25 the estimated capital budget is circa £80m.
- There is huge variation in the public health grant received by each of NEL's local authorities from central government. The variation is at odds with the government's intended formula (which is based on standardised mortality ratios of less than 75 ((SMR<75)) and is the result of grants largely being based on historical public health spend. This impacts on our ability to invest upstream in preventative services.
- As a system the majority of our spend is on more acute care and we know that this is driven by particular populations (0.3% of the population account for 10% of costs associated with emergency admissions; just under 20% account for 65%).
- We now have an opportunity as a system to improve the outcomes of our local people by concentrating on population health needs, and therefore focusing more of our investments on prevention and securing greater equity for our residents. We intend to do this by focusing on what improvements in outcomes that are needed and allocating resources towards those outcomes.




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

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

# We are further developing opportunities for research and innovation

We are actively growing our research and innovation architecture to ensure we can deliver better outcomes for our growing population as well as enabling greater value for money and sustainability as a system.

Our emerging research and innovation strategy will support our learning system ethos and align with the plans developed for research by our Place and Provider Collaborative teams. We will build on the existing research infrastructure and expertise across NEL and expand the opportunities for local people and health and care professionals to be involved in research. We have three emerging objectives of the strategy:

A. Supporting relevant, local research activity

B. Setting the direction and attracting relevant local research and innovation

C. Developing a system and the partnerships that enable evidence-informed decision making and quality improvement

**NEL already hosts a wealth of research and innovation assets:**

- The Clinical Effectiveness Group (CEG) at Queen Mary University London (QMUL) established 30 years ago uses data to support primary care improvement in population health (NEL ICS has just been ranked first nationally in cardiovascular disease (CVD) prevention and outcomes).
- Care City is an innovation centre for healthy ageing and regeneration with a mission for happier and healthier older age for east Londoners, achieved via research, innovation and workforce development.
- EQUIP (Enabling Quality Improvement in Practice) works across east London primary care supporting staff engagement and improvement approaches.
- We are also an active member of the North Thames Clinical Research Network, North Thames Applied Research Collaborative and University College London Partners (UCLPartners).

**Bart's Life Science**

A local and national asset it will bring infrastructure and researchers to work alongside businesses and entrepreneurs. Aiming to be world leading in prevention, prediction & precision.

- Working with a highly diverse population, we will make a significant impact on health inequalities
- Extending and developing our clinical research capacity
- Using big data and AI to develop analytic and predictive tools
- Precision medicine for targeted interventions
- Creating thousands of jobs and economic impact

Innovation is also at the heart of new developments in NEL – we are launching a **Research Centre for Healthy Ageing** at Whipps Cross Hospital. The centre led by Barts Health and QMUL will create a collaborative network of clinicians, researches, educators, policymakers working with local communities researching how to transform how services work for older people, supporting them to live well and independently. Other developments we are scoping include the opportunities for life science developments in Whitechapel and a partnership with the national Dementia Research Institute to support our centre of excellence for older people at East Ham.

# 5. How we are transforming the way we work

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

- The previous section set out the challenges that the north east London health and care system needs to address to succeed in its mission to create meaningful improvements in health and wellbeing for all local people.
- This next section summarises our portfolio of transformation programmes, which have evolved organically over many years: rooted in the legacy clinical commissioning groups (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.
- These transformation programmes have not previously been shaped or managed as a single portfolio.  In aligning them to a single system integrated care strategy we hope to being greater clarity and coherence, as well as create opportunities for connecting and accelerating our work.
- This section sets out how partners across north east London are responding to the challenges described in the previous section. It describes how they are contributing to our system priorities by considering five categories of improvement outlined below.

1. Our core objectives of high-quality care and a sustainable system
2. Our NEL strategic priorities
3. Our supporting infrastructure
4. Place based Partnerships priorities x7
5. Our cross-cutting programmes

# The role of the provider collaboratives in delivering our transformation programmes

Within north east London we have five provider collaboratives covering acute care; mental health, learning disabilities and autism; community care; primary care; and the voluntary, community and social enterprise sector. They play a key role in the delivery of the transformation programmes across our partnership and work closely with our seven places and our local people. We have included an introduction to each of the collaboratives below, as well as the specific transformation programmes they host.

**What is a provider collaborative?** It is an opportunity for our providers to work together at scale across multiple places and provide leadership to reduce unwarranted variation and inequality in health outcomes, access to services and experience.

**Acute provider collaborative (APC)**
The APC consists of the ICB and our three acute providers:

- Barts Health NHS trust
- Barking, Havering and Redbridge University Hospitals NHS trust
- Homerton Healthcare NHS Foundation Trust

**Vision / Aim(s)**: to create the conditions that enable clinicians to collaborate more easily and effectively for the benefit of our patients and community. Together we will enable resilient acute hospitals that serve the needs of our residents, with focus on delivering high quality clinical services, accelerating access to care and implementing a sustainable financial model.

**Transformation programme:** the APC hosts the planned care programme, the cancer alliance, and the critical care network. It also includes the specialised services and research & clinical trials programmes, and is focussed on corporate services, including procurement and workforce/temporary staffing.

**Mental health, learning and disabilities, and autism collaborative (MHLDA)**

The MHLDA collaborative consists of the ICB and our two MHLDA providers:

- East London NHS Foundation Trust
- North East London NHS Foundation Trust

**Vision / Aim(s)**: to work together to improve outcomes, quality, value and equity for people with, or at risk of, mental health problems and/or learning disability and autism in NEL.

**Transformation programme:** the MHLDA collaborative hosts the mental health, learning disability and autism programmes. This includes children and young peoples' mental health and emotional wellbeing, as well as a focus on inpatient quality and urgent and emergency care.

**Community Health Services collaborative (CHSC)**

The CHSC consists of the ICB and five CHS providers:

- Barts Health NHS trust
- Barking, Havering and Redbridge University Hospitals NHS trust
- East London NHS Foundation Trust
- Homerton Healthcare NHS Foundation Trust
- North East London NHS Foundation Trust

**Vision / Aim(s)**: to create a consistent and integrated CHS offer across NEL, ensuring consistent and high quality of care for the residents in NEL by focusing on resident engagement, reducing variation and improving access to services across our seven places.

**Transformation programme:** the CHSC hosts the CHS programme, including management of improvement networks.

**Primary care collaborative (PCC)**

The PPC consists of the ICB and providers of all the north east London primary care services including general practice, pharmacy, dentistry and optometry

**Vision / Aim(s)**: to develop and agree a NEL primary care strategy to inform the contracting and transformation of services in order to reduce inequities in care provision and unwarranted variation in outcomes for patients and residents

**Transformation programme:** the PCC hosts the primary care programme, which includes the Fuller Programme.

**Voluntary, community and social enterprise sector collaborative (VCSE)**

**Vision:** The collaborative is committed to tackling health inequalities and to improving population-level health, especially for and with those living in areas with higher levels of deprivation and for and with population groups experiencing the poorest health outcomes. We know that no one sector has all the answers, and so we work equitably with statutory partners across north east London's Integrated Care System to discover innovative solutions that improve the health and wellbeing of our growing population of just over 2 million people. To ensure we reach these groups, we work locally at place. Where it makes sense to do so, we collaborate on a system level approach. We always work alongside the wider sector to respond to community needs.

# Urgent and emergency care

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

**Portfolio vision, mission and key drivers:**

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

**Key stakeholders:**

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

**Key programmes of work that will deliver the vision and mission**

The work within the portfolio is mapped against our strategy goals and four outcomes. **1) strengthening provision and access to alternative pathways, 2) optimising flow through hospitals, 3) using population health management to keep people well in the community and 4) setting up governance and pathways to form system wide sustainable plans**.

There are a range of projects to deliver on these outcomes that have been divided into directly managed by UEC portfolio and those sitting in other portfolios.

UEC directly managed – 111 procurement and development, hospital flow, ambulance flow, system co-ordination centre, urgent treatment centres, virtual wards and winter planning.

Other delivery areas such as same day access, urgent community response, mental health pathways and planned care sit in other portfolios but will be monitored and reported to the UEC Board. Additionally establishing the NEL UEC programme management office (PMO) and governance will provide infrastructure to deliver a measurable impact.

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

One to ones throughout the summer to understand local strategies and plans to build up the NEL UEC portfolio. Work underway to propose new ways of working and governance structures. Collaboration will be at the heart of the portfolio.

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

April 2025:

- System co-ordination centre set up in line with specification - April 2026
- Reduction in delayed discharges and improvements to A&E performance
- Elimination of ambulance handover waits over 45 minutes - April 2027
- 111 provider working to a new specification following procurement process
- Expansion and coordination of virtual wards beds

**Engagement with the public:**

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

# Community health services

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

**Portfolio vision, mission and key drivers:**

- Develop a consistent community services offer across NEL (new core offer and nursing model)
- Supporting neighbourhoods and Places to enable people to stay well and independent, for as long as possible, wherever they call home
- Creating wider system value by unlocking system productivity gains i.e. reduction of hospital admissions
- Using evidence to understand the totality of services, outcomes and resources across NEL, identifying opportunities for improved outcomes
- Create and facilitate collaborative partnerships with system partners including local authorities, primary care, health providers, and the independent voluntary and charitable sector
- Improve resource allocations for residents ensuring taxpayers get better value for money
- Supporting wider system pressures by maximising Community Health Services (CHS) opportunities (i.e. LAS call outs, UEC attendances, unplanned care, LA residential care pressures)
- Continuous Improvement of population health and care outcomes working closely with stakeholders and residents

**Key programmes of work that will deliver the vision and mission**

- Leading a joint approach to Planning for the first time across NEL and continuing to promote and embed the process of joint working
- Developing and evolving Improvement Networks, bringing together subject matter experts with clinical leads and residents creating a conducive environment to design best practice pathways and consistent offers across NEL. For example NEL are establishing Improvement networks for MSK, Babies, children & young people (BCYP) with neuro diverse needs, BCYP SALT and Rapid Response.
- Improvement Networks will also support our broader community nursing offer for adults and BCYP
- Working with Places to ensure Integrated Neighbourhood Teams maximise opportunities for integration (e.g. building on the work of Child health hubs)
- Increasing capacity and support to UEC pressures by bringing together pathways and opportunities across virtual wards, rapid response teams, community beds and proactive care
- Redesigning priority and pressured pathways with residents and stakeholders, for example within MSK and SALT.
- Implementing digital transformation across large and smaller CHS to improve service provision i.e. management of UCR 111 calls
- Leading the approach to contractual best value jointly with PLACE colleagues, maximising productivity, best value and consistent CHS offers that are reflected in revised contracts
- Focused work on understanding current and future population needs across NEL and at PLACE, including demand, capacity, productivity, user and carer experience and outcomes.

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

- Consistent pathways and models for CHS in development minimising variances in outcomes and experience
- Maximising opportunities to integrate and avoid duplication
- Improved outcomes for residents including better access to quality services in the community / close to home or at home

**Key stakeholders:**

- Residents
- 7 Places / Boroughs
- ELFT – East London Foundation Trust
- NELFT – North east London Foundation Trust
- Homerton Hospital & Barts Hospital
- 65+ bespoke providers/ Provider Network
- Clinicians

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

- Joint planning sessions since Nov 2023 (45+ people across Places and providers)
- Regular engagement with Place directors and Provider operational leads
- Joint working across collaboratives and programmes such as UEC , LTC, BCYP, Mental health, Planned care (i.e. the approach to Virtual care, joint MSK approach with Planned care)

**Engagement with the public:**

- Patient engagement at an early stage but conversations with Patient experience leads occurred in 2023 to utilise existing forums
- Additional programme/collaborative capacity April 24 will enable a focused approach to engagement across all Improvement networks as they develop

# Primary care

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

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

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

**Key programmes of work that will deliver the vision and mission**

- There are a range of programme that make up the primary care portfolio to ensure the delivery of our goals.
- **Empowering patients** - supporting patients to manage own health, stay healthy and access services. **Improving access** - providing a range of services and assistance to respond to patient needs in a timely manner. **Modernising primary care** - developing new and digital tools to support highly responsive quality care. **Building the workforce** - staff recruitment, retainment and develop plans in place to improve job satisfaction and flexibility. **Working smarter** - reduced workload across primary/secondary services and improvements to sustainable and efficient ways of working. Optimising enablers - estate, workforce and communication plans to support the implementation of our goals.
- Integrated Neighbourhood Teams (INT) are pivotal to transforming Primary Care and will be delivered through work responding to the Fuller recommendations. **A framework** will offer a streamlined approach for the delivery by integrating Primary Care, including Pharmacy, Optometry and Dentistry, alongside wider health care, social care and voluntary sector organisations. INTs will facilitate care, through 'teams of teams' approach enabling **continuity of care**. These teams will also be instrumental in broadening the availability of care, providing **extended in and out-of-hours services,** including urgent care. A **single point of contact through advanced cloud-based telephony systems** will streamline access to care, while **improved signage and navigation** will guide patients to the right services.
- The Fuller initiatives are accompanied by other enabling programmes. **People**, will bolster the **capacity of the ARRS roles**, **establish training and development opportunities**, and **determine the ideal workforce** for INTs. Infrastructure, including, Estates and Data will align current plans to INT requirements, as well as **Digital First** which aims to improve digital access (including remote consultation), NHS App usage, improving practice efficiency and increasing competence to use digital tools.
- Wider programmes which are fully or partly delivered through primary care providers, include, **Pharmacy,** enhancing the role of the community pharmacy to improve access and patient self-management, **Long Term Conditions (LTCs),** including a range of interventions such as case-finding, annual or post-exacerbation reviews for targeted patients, as well as programmes that sit in other collaboratives such as **Personalisation** and **Vaccinations**. Other transformational projects to improve dental and optometry services will be developed in the future as their provider groups mature.

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

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

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

**April 2026:**
•All practices will be CQC rated as GOOD or have action plans to achieve this further equalisation of enhanced services.

**April 2028:**
•Streamlined access to a universal same-day care offer, with the right intervention in the right setting and a responsive first point of contact

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

# Planned care

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

**Portfolio vision, mission and key drivers:**

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

**Key stakeholders:**

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

**Key programmes of work that will deliver the vision and mission**

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

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

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

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

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

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

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

**Engagement with the public:**

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

# Cancer

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

**Portfolio vision, mission and key drivers:**
The North-East London Cancer Alliance is part of the North East London Integrated Care System and is committed to improving cancer outcomes and reducing inequalities for local people.
Our aim is that everyone has equal access to better cancer services so that we can help to: - Prevent cancer, Spot cancer sooner, Provide the right treatment at the right time, Support people and families affected by cancer
**Drivers:**
Our work enables the ICB to achieve its objectives, as set out in the strategy, across the ICB's six cross-cutting themes:
Tackling Health Inequalities, Greater focus on Prevention, Holistic and Personalised Care, Co-production with local people, Creating a High Trust Environment that supports integration and collaboration, Operating as a Learning System driven by research and innovation

**Key stakeholders:**
- Patient and Carers
- Providers, Partners, Place
- Cancer board
- APC Board and National / Regional Cancer Board

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

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**
- Weekly area prescribing group (APG) Operational delivery meeting
- Tumour specific Experts Reference Group (ERG)
- Project Delivery Groups (PDG)
- Cancer board – internal assurance
- Programme Executive Board – NEL operational delivery
- APC Board, cancer board and National / Regional Cancer Board

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

**2025/26:**
- Access to Targeted Lung Health Check service for 40% of the eligible population
- Invitation for up to 45,000 people into the Grail pilot study
- Continued mainstreaming as part of the Lynch Syndrome pathway
- Improved quality of life and experience of care.

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

**Engagement with the public:**
- Patient Reference groups
- Campaign workshops

# Maternity

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

**Portfolio vision, mission and key drivers:**
The 3 year delivery plan for maternity and neonatal services: 2023-2026. This has consolidated the improvement actions committed to in Better Births, the NHS Long Term Plan, the Neonatal Critical Care Review, and reports of the independent investigation at Shrewsbury and Telford Hospital NHS Trust and the independent investigation into maternity and neonatal services in East Kent. The expectations on Local Maternity and Neonatal Systems (LMNS) are that they focus on the following areas;

- Listening to, and working with, women and families with compassion
- Growing, retaining, and supporting our workforce
- Developing a Culture of safety, learning and support
- Standards and structures that underpin safer, more personalised and more equitable care

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

**Key programmes of work that will deliver the vision and mission**

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

**Details of engagement with places, collaboratives and other ICB portfolios**
All LMNS and APC board Stakeholders (PBC, LA, Trusts, MNVPs- service users, Third sector organisations) Regional Maternity Transformation Team, Chief Midwife Office, ICB BCYP, Public Health.

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

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

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

# Babies, children and young people

## 2. Our NEL strategic priorities

**Portfolio vision, mission and key drivers:**

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

**Mission:** The BCYP Programme aims to reduce unwarranted variation and inequality in health and care outcomes, increase access to services and improve the experience of babies, children, young people, families and carers and strengthen system resilience. Through strong working relationships across health and social care partners, we will increase collaboration, enhance partnership working and innovation, share best clinical and professional practices with each other and deliver high quality services.

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

**Key stakeholders:**

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

**Key programmes of work that will deliver the vision and mission**

**Acute care** - priorities are CYP elective care recovery, diabetes, allergy and addressing urgent and emergency care priorities for BCYP.

**Community-based care** - priorities are local integrated care child health pilots, increasing capacity (including 7-day access to children's community nursing and hospital@home), improving children's community service waiting times;

National/regional mandated priorities including long term conditions;

**Primary care** – priorities are BCYP unregistered with a GP, young peoples access to integrated health hubs; 'You're Welcome standards and Child Health training curriculum;

**Special Education Needs and Disabilities (SEND)** - SEND Inspection Readiness Group to ensure Places and ICB are prepared for new Ofsted Inspection framework and are meeting NHSE requirements. Focus Areas – Autism and Diagnostic pathways and Pre and Post offers of support for families.

Special cohorts including Child Sexual Abuse (CSA) hub, looked after children and care experienced young people.

**Oral health** - focus on access to dental services for more vulnerable population groups that find it harder to access services. In partnership with LAs, the ICB plans to develop Oral Health promotion activities as part of the wider strategic prevention programme with initiatives such as Supervised Tooth Brushing in Schools. Delivery across dental services will be closely monitored and where opportunities arise for additional investment, these will be explored with a view to rapid implementation to maximise the in-year effect. For children requiring hospital treatment, we will continue to work with the community dental services provider, Kent Community Healthcare, along with providing additional treatment options at the Royal London Hospital, with support from Bart's Health.

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

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

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

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

**Engagement with the public:**

Via Providers.
SEND Parent's Forum
National Voices

# Long term conditions

## 2. Our NEL strategic priorities

**Portfolio vision, mission and key drivers:**
**Our vision** - To support everyone living with a long-term condition in north east London to live a longer, healthier life and to work to prevent conditions occurring for other members of our community, and support communities to prevent LTC onset or progression
**Mission** - Listening to communities to understand how we can support patients in managing their own conditions

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

**Key drivers** – Long-term conditions have a national and regional focus as a core component of the Long Term Plan, with attention on Cardiovascular disease, stroke, diabetes, including work to achieve type 2 diabetes remission, and respiratory. Embedded in the LTC workstreams are plans to address health inequalities, including utilising the Core25Plus approach and Innovation for Healthcare Inequalities Programme. Furthermore: Long-term conditions (LTCs) is 1 of NEL's 4 System Priorities for improving quality and outcomes and tackling health inequalities. This is reflected in Place-based priorities which all have identified one or more LTCs. Across NEL, one in four (over 600 thousand people) have at least one long-term condition, with significant variation between our places (in Havering, the figure is 33%, vs 23% in Newham and Tower Hamlets). NEL is the highest performing ICB in England for many outcomes related to CVD, stroke, and renal, but local social demographics put the system at risk of continued growth in demand. Nationally, long-term conditions account for half of GP appointments, 64 percent of all outpatient appointments, and over 70 percent of all inpatient bed days. The most deprived areas, people acquired three or more conditions (complex multimorbidity) when they were 7 years younger, compared with the least deprived.

**Key programmes of work that will deliver the vision and mission**
**Primary LTC prevention & Early identification:** Social determinants of health (SDOH) impact 80% of health outcomes from chronic disorders and across NEL we have areas of significant deprivation which is linked with increased prevalence of long-term health conditions and lower life expectancy. We want to work with our local population to empowering and enabling people to manage their own health and engage in healthy behaviours across their lives, so they don't develop a LTC.
**Secondary prevention and avoiding complication:** DH data has demonstrated that 9 out of 10 strokes could be prevented and up to 80% of premature CVD deaths are preventable, if risk factors could be controlled. Working with social communities, and ensuring we provided person focused early identification, secondary care and avoiding complication enables us to improve outcome and reduce exacerbation of an LTC
**Co-ordinated care and equability of service:** Across NEL, one in four (over 600 thousand people) have at least one long-term condition, with significant variation between our places. The feedback from the Big Conversation reflects the need to join-up care and move forwards person focused approach. Working with colleagues at place we aim to continue to review current provision and reduce unwarranted variation in care across the pathway, with an aim of improving health outcomes
**Enabling people to live well with a LTC and tertiary prevention:** The effective support and management of LTC will increasingly require the management of complexity and moving away from a single condition approach. In NEL 3 in 5 patients with a diagnosed long term condition have only one condition, the other 2 in 5 have multiple co-morbidities, of which diabetes and hypertension were most common.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**
**Work toward national targets including:** Improve detection of atrial fibrillation and ensure appropriate stroke risk reduction through anticoagulation - by 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation. Improve detection of undiagnosed hypertension and ensure those with hypertension are controlled to target – by 2029 80% of expected numbers with hypertension are detected and 80% of people with high blood pressure are treated to target. Improve access to and uptake of Cardiac Rehabilitation (CR) – by 2029 85% of eligible patients are accessing CR. Reduction of type 2 diagnoses / delayed onset in residents developing Type 2 (T2) diabetes delivered through an increase the number of people referred and starting the National Diabetes Prevention Programme (DPP) 45% of eligible populations). Symptoms of Transient Ischaemic Attack will have access 7 days a week to stroke professionals who can provide specialist assessment and treatment within 24 hours of symptom onset thus preventing long term disability

**Key stakeholders:**
Residents and communities, Place based teams, Regional and National colleagues, Organisation Delivery Networks, Voluntary organisations, Specialised Services, Pharmacy and Medicine Optimisation, Primary care, Babies, Children and Young People, NEL collaboratives, Planned care, Mental health programme, Urgent Care programme, BI and insights, Contracting and finance.

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**
Places – working with Heads of Live well across who are responsible for LTCs
Clinical/improvement Networks – including trusts, community providers, pharmacy, primary care and place
Organisation Delivery Networks (renal and CVD/cardiology).
Programme directors for specialised service, community, mental health, BYCP.

**Engagement with the public:**
The big conversation outputs are incorporated into prioritisation for 24/25.
Furthermore, we have incorporated feedback at service level.

# Mental health, learning disabilities and autism

## 2. Our NEL strategic priorities

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

The service user and carer priorities that represent our key drivers include:
- Improving peoples' experience of accessing mental health services, including their first contact with services, and ensuring equity of access
- Children and young people can access different support from different people, including those with lived experience, when and where they need it
- People with a learning disability have the support they need and a good experience of care, no matter where they live

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

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

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

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**
- Improved access, outcomes and experience of NHS Talking Therapies for minoritised communities and other under-served populations
- Improved system-wide response to children and young people presenting with self-harm through the introduction of new evidence-based interventions, including better support to teachers, GPs and parents
- Improved offer of pre-diagnostic, diagnostic and post-diagnostic support for people with neurodevelopmental support needs
- Greater equity in the community learning disability support offer across boroughs
- Improved inpatient services with lower lengths of stay, and better options of high-quality supported housing / residential care for those who need it
- Widespread adoption of personalised and person-centred care planning processes with an emphasis on continuity of care and biopsychosocial assessment

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

# Employment and workforce

## 2. Our NEL strategic priorities

**Portfolio vision, mission and key drivers:**

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

**Key stakeholders:**

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

**Key programmes of work that will deliver the vision and mission**

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

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

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

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

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

**Engagement with the public:**

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

# Specialist commissioning

## 3. Our supporting infrastructure

**Portfolio vision, mission and key drivers:**
**Our Vision:** To ensure that the population of north east London have good access to high quality specialist care that wraps around the individual, and ensures the best possible outcomes
**Our mission and drivers:**
- We are responsible for planning and commissioning of delegated specialised health services across north east London. We are responsible for specialised spend, performance and outcomes, and ensuring all parts of the local health system work effectively together to deliver exemplary specialist care.
- We are responsible for integrating pathways of care from early intervention and prevention of LTC through to specialist provision, ensuring end to end pathways to improve outcomes and manage future demand of costly specialist care.
- We set priorities for specialised services and work with our local ICS, multi ICB partners and London regional partners to deliver world class specialised services to benefit patients within north east London, North London or London ensuring access to the right level of care.
- We will do this by working together with health partners, specialist providers, local authorities and the voluntary community and social enterprise (VCSE) sector, with residents, patients and service users to improve how we plan and deliver specialised services.

**Key stakeholders:**
NHS London Region and London ICB partners, NEL Provider Trusts, North London ICB Programme Board partners (north central and north west London), Operation delivery networks (ODNs), mandatory and local clinical networks, East of England Region, Local authorities, VCSE

**Key programmes of work that will deliver the vision and mission**
From 2024/25, ICBs will have budget allocated to them on a population basis, and from April 25 this will be allocated on a needs based allocation basis. The specialised allocation will follow a similar formula to that of other nonspecialised services that ICBs hold, and so can be considered and contracted for alongside the rest of the pathways we commission. Delegation of specialised services and transformation of specialised services allows us to consider the totality of resources for our population, making it easier to ensure investment in the most optimal way to improve quality and outcomes, reduce health inequalities and improve value.
The key programmes of work are to:
1. Ensure safe delegation of specialised services working alongside the NHS England (NHSE) regional team
2. Joint work with NHSE, London ICBs and locally in NEL focussed on specialised transformation: sickle cell disease (Haemoglobinopathies), HIV and Hepatitis (including liver disease), Renal disease, Neurosciences, Cardiology, complex urogynaecology and specialist paediatrics
3. Working alongside other portfolios will deliver this mission, mainly LTC to ensure a whole pathway approach routed in place, cancer, planned care, critical care, BCYP and mental health

**Details of engagement with places, collaboratives and other ICB portfolios**
- APC Executive, APC Joint Committee, NEL Executive leads,
- Close working with other ICB portfolios: LTC, Cancer, Planned Care, Critical Care, CYP, mental health

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**
**HIV:** People living with human immunodeficiency viruses (HIV) will have improved follow up care with investment in a community led peer programme with an aim to reduce by 70% the number of eligible patients that are lost to care/failed by care. This follow up care will include regular testing, counselling, mentoring, group support, assurance and information and advice.
**Renal:** Working towards maximise patient dialysing at home - 496 patients on home therapies by 31/32 (target of 28% of patients on home therapies by 2032). Working towards maximise patients being transplanted - 280 transplant operations completed in 31/32.
**Sickle Cell:** Local people with sickle cell will receive appropriate analgesia and other pain management measures (ideally within 30 minutes) when attending any acute A&E in NEL . Residents will have timely access to multi-disciplinary team to support delivery of trauma-informed care based on the principles of safety, trust, choice, collaboration, empowerment and cultural competence.
**Hepatitis and HIV:** To achieve micro elimination of Hep-C virus across NEL (2025). Improved access to diagnostics and increase local prevention programmes by aligning with the British Liver Trust optimal pathway. This will support the reduction in the growth rate of liver disease (currently 20%).
**Neurosciences**:10% of eligible stroke admissions will have consistent 24/7 access to mechanical thrombectomy to reduce the impact of stroke. Improve detection of atrial fibrillation (AF) and ensure appropriate stroke risk reduction through anticoagulation - by 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation.
**Cardiology:** Shorter waiting times and reduced elective and non-elective. Heart failure (HF) 30 day readmission rates have recently risen to more than 20%. We aim to reduce this to reduce this <15% with roll out of dedicated HF pharmacist to review and titrate patients post discharge.

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

# Digital

3. Our supporting infrastructure

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

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

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

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

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

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

- System-wide infrastructure strategy under development and centralised capital pipeline
- Members of the digital team attend portfolio and collaboratives' meetings. A meeting has taken place with place directors but further meetings are needed

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

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

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

# Physical infrastructure

3. Our supporting infrastructure

**Portfolio vision, mission and key drivers:**
North east London is already home to many state-of-the-art facilities, however, too much of our estate is not fit for purpose, whether that is inaccessible primary care facilities, or safety and compliance in some of our acute settings. Our system has been hampered by undercapitalisation which means that investment is swallowed up by maintaining current estate rather than enabling investment in new innovations that would create better value. Inadequate investment also weakens our resilience to the growing threats of climate change. 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.

Our emerging NEL Infrastructure Strategy contains 5 draft priorities:
1. Align infrastructure investment to system priorities
2. Improve infrastructure quality
3. Enable increased productivity
4. Integrate services and across community assets
5. Accelerate innovation

**Key stakeholders:**
All ICS health and care providers, local authorities (planning, regeneration and property), third sector organisations and London Estates Delivery Unit

**Key programmes of work that will deliver the vision and mission**
To support achieving the benefits we want to see for our population, our challenge in NEL is twofold: to take a forensic approach to sorting out the basics that will create the foundation for high quality services and health creating communities; while also accelerating innovation towards better outcomes and value for a population that is growing in both size and complexity. Across NEL ICS organisations exist a multitude of estates projects in the pipeline, scheduled to be delivered over the next 5 /10 years, these include:
- The redevelopment of Whipps Cross hospital and a new centre on the site of St George's, Hornchurch
- Formal opening of a new St George Health and Wellbeing Hub – Spring 2024
- Acute reconfiguration, that encompasses the estimated total value for Whipps Cross Redevelopment
- Mental Health & Primary and Community Care infrastructure developments
- IT systems and connectivity, aligned with the NEL Strategic digital investment framework
- Medical Devices replacement
- Backlog Maintenance works
- Routine Maintenance including PFI (private finance initiatives)

**Details of engagement undertaken with Places, collaboratives and other ICB portfolios**
- System-wide infrastructure strategy under development and centralised capital pipeline
- Capital overseen by Finance, Performance and Investment Committee of NHS NEL.
- Local Infrastructure Forums meeting regularly in the seven places

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**
- Additional facilities and access to services in the community (primary care, community diagnostics, integrated care, theatre capacity)
- Better patient experience whereby improvements and maintenance to existing sites is being undertaken

**Engagement with the public:**
Digital placemaking scoping project undertaken to determine public expectations of NEL buildings

# Finance

3. Our supporting infrastructure

**Portfolio vision, mission and key drivers:**
Our aim is to achieve financial stability over the short to medium term – recognising the significant challenges the system faces this year and next – while also ensuring that we have a sustainable model over the medium to long term, by beginning the transformation of services now so that services are not overwhelmed by future demographic growth.

**Key drivers:**
- Incentivising transformation and innovation in clinical practice and the delivery of services to improve the outcomes of local people
- Supporting delivery of care closer to patients' homes, including investing in programmes that take place outside the hospital environment
- Refocus how the money is spent to focus on population health, including proactive measures that keep people healthier and to level up investment to address historical anomalies of funding
- Increasing investment in prevention, primary care, earlier intervention and the wider determinants of health, including environmental sustainability
- Ensuring that all partners are able to understand and influence the total amount of ICB resources being invested in the care of local people

**Key stakeholders:**
- Reporting to the ICB Board and Place Partnership Boards
- Finance, Performance and Investment Committee
- Audit and Risk Committee
- Chief Finance Officer (CFO) lead monitoring of monthly and forecast performance

**Key programmes of work that will deliver the vision and mission**
- Supporting our providers to reduce transactional costs, improve efficiency and reduce waste and duplication
- Support the financial stability of our system providers and underpinning a medium to long term trajectory to financial balance for all partners
- Ensuring we do not create unnecessary additional financial risk, especially in the acute sector
- ICS investment pool to fund programs designed to reduce acute demand
- Finance development programme to agree overall budgets and develop place based budgets and budgetary delegation to place
- Effective integration of specialised commissioning, community pharmacy, dental and primary care ophthalmology services
- Supporting the integration of health and social care for people living with long term conditions who currently receive care from multiple agencies

**Details of engagement undertaken with places, collaboratives and other ICB portfolios**
Finance leads from our system partners, for example Hospital Trust CFOs, are part of the ICB finance committees and networks, and will contribute toward how the finance structures and models are developed as we evolve as a system.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**
- Improving quality and outcomes for local people of north east London
- Securing greater equity for our residents
- Maximising value for money
- Deepening collaboration between partners

**Engagement with the public:**
Insight from engagement with the public, such as the big conversation, feeds into the design of the way we are operating.

# Barking & Dagenham

## 4. NEL Place based Partnership

**Portfolio vision, mission and key drivers:**

**Vision**

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

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

**Interdependent ICB programmes**

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

**Interdependent Collaborative programmes**

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

**Key programmes of work that will deliver the vision and mission**

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

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

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

**Key stakeholders:**

- NELFT
- Primary care/PCNS
- BHRUT/ Barts
- VCSE
- Healthwatch
- Local Authority- childrens and adults services; public health
- Estates and housing teas

**Engagement with the public:**

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

# Havering

## 4. NEL Place based Partnership

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

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

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

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

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**
Under the programmes Start Well, Live Well, Age Well and Die Well Havering PbP aims to deliver by 2025 and 2027:
- A reduction in the number of children and their families attending emergency departments for non-emergency care
- Reduce the number of children who are physically inactive and/or obese
- Increase the number of social prescribing referrals to support people to access wider wellbeing support
- Increase the number of cancers being diagnosed at an earlier stage
- Increase the number of older people with a personalised care and support plan
- Reduce the number of frail older people living in cold, damp or moldy homes
- Reduce the percentage of older people who die within 7 days of an emergency hospital admission
- Increase the access to bereavement support in Havering

** Full details of the programme ambitions are captured in the Havering Place based Partnership interim strategy*

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

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

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

# Redbridge

## 4. NEL Place based Partnership

**Redbridge vision, key priorities & key drivers:**
**Vision:** The Redbridge Place Based Partnership will relentlessly focus on improving the outcomes for the people of Redbridge and seek always to make a positive difference to people's lives. Together, we will build on what we have already achieved and use our combined resources to create person-centred, responsive care to build services around the needs of our communities within Redbridge. We will have a strong focus on prevention, addressing inequalities and the wider determinants of health.
**Key priorities: Start Well:** Improve Access to Universal and Community Services, Deliver the Special Education Needs and Disability (SEND) Agenda, Improve Holistic and Early Years' Service Provision, Improve support for Emotional Wellbeing and Mental Health (MH) for Children and Young People (CYP). **Live Well:** Improve Diagnosis and outcomes for Long Term Conditions through Targeted Community Engagement, Develop a Cardiology and Respiratory Plan, Improve Learning Disabilities and Autism (LDA) Health Check Rates. **UEC:** Develop a Programme to Improve Self-Care to reduce inappropriate use of UEC services, Develop Resources that support staff and Public to Access Services, Facilitate a Safe, Swift and Supported Discharge post Hospitalisation. **Ageing Well:** Supporting People to know what services are available and how to access them, , Keeping People Well in a Place they Call Home, Making Redbridge a Great Place to Grow Old and fostering inclusion and a sense of community. **Primary Care**: Improve Childhood Immunisation Rates, Support the 'Fuller Stocktake Report' Programme, Development of Same Day Access Model, Improve Recruitment and Retention of Primary Care Staff, Support Development of Ilford Exchange, Support the Development of new models of Care including Neighbourhood Teams, Strengthening Multi-Disciplinary Teams (MDTs). **Key drivers for success:** Good governance and accountability, a focus on the voice of those with lived experience, a focus on Organisational Development, a commitment to working in partnership and beyond organisational boundaries

**Interdependent Integrated Care Board (ICB) Portfolios**
Long Term Conditions (LTC), Learning Disabilities (LD), Autism and Mental Health (MH), Planned Care (PC), Health Inequalities (HI), Primary Care, Babies children & young people, urgent & emergency care, older people and cancer

**Interdependent Provider Collaboratives**
Community Collaborative, Acute Provider Collaborative, Cancer Collaborative, Primary Care Collaborative, Mental health collaborative and Voluntary community sector collaborative.

**Key programmes of work that will deliver the vision and key priorities: (Some Programmes of Work will be existing Projects while other areas are still in Development)**
**Start Well**: Develop and Deliver a Paediatric Integrated Nursing Service (PINs), Learning Disability Key workers, Develop Integrated child health hubs in Primary Care using a Multi-Disciplinary Team (MDT) Approach, A programme to Improve links between Maternity and Early Years Provision, Deliver the Special Education Needs & Disability (SEND) programme, **Live Well**: Review of the Cardiology and Respiratory Workstreams, Projects to address Long Term Conditions (LTC) undiagnosed patients, A review of areas where partners are aligned or overlap with Services, Develop a Population Health Approach to how we use information, Review of the Mental Health (MH) Liaison Service at King George Hospital (KGH), A programme to promote awareness and training for Learning Disabilities (LD) and Autism. **UEC:** Develop a Redbridge focussed UEC Plan. Review key services to identify overlaps including reviewing Substance Misuse pathways and increasing Community Treatment Team (CTT) capacity in 2024/25. Deliver a programme to reduce inappropriate use of ED and UTC services including: developing a Redbridge Communications and Engagement Plan which takes into account local communication preferences, support to self-care and a programme to support those unregistered to register with a GP practice. **Ageing Well**: Collate and update information on Dementia, End of Life and falls services for patients, Develop a local pro-active approach to care with system partners across Falls, Carers support, End of Life and Fitness and Nutrition, Develop and deliver a programme to tackle Isolation, Support and encourage older people to access Talking Therapies, Develop and pilot a range of Intermediate Care discharge models in bed-based units. **Primary Care: S**upport implementation of the Fuller workstreams, access recovery plan including PCN capacity and access plans, transitional funding, implementation of cloud based telephony and other primary care digital projects, like the NHS App. The continued development of the same day access model including the same day access hubs. **Health Inequalities:** A range of projects undertaken by local partners across the health, care and voluntary sectors will seek to address differing health inequalities experienced by local communities. The projects are wide ranging and work with people who face a variety of complex interrelated issues but all seek to take a person centred and holistic approach. This is underpinned by the NHS Core20Plus5 approach. **Ilford exchange health centre:** To develop and deliver a new health centre in Ilford town centre following an extensive public consultation in September 2022.

**Summary of benefits / impacts Redbridge people will experience by April 2025:**
**By April 2025 the Redbridge Place Based Partnership will Deliver:**
- A reduction in undiagnosed Long Term Conditions and improved diagnosis rates
- Improved End of Life Care services for People in Redbridge
- Improved services for Children and Young People with mental health issues
- Improved uptake of childhood immunisations
- Improvements against the Accessibility Information Standards
- Significantly reduce health inequalities underpin by the Core20+

**Key stakeholders:**
- London Borough of Redbridge (LBR)
- Community Action Redbridge (CAR)
- Healthwatch
- Healthbridge (GP Federation),
- The Primary Care Networks (PCNs) in Redbridge
- North East London NHS Foundation Trust (NELFT),
- NHS NEL Integrated Care Board (ICB)
- Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT)
- Barts Health NHS Trust (specifically Whipps Cross)

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

# Tower Hamlets

## 4. NEL Place based Partnership

**Portfolio vision, mission and key drivers:**

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

**Interdependent ICB programmes**

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

**Interdependent Collaborative programmes**

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

**Key programmes of work that will deliver the vision and mission**

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

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

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

**Key stakeholders:**

- LB Tower Hamlets
- NEL ICB
- Barts Health Trust
- TH GP Care group
- ELFT
- Healthwatch
- TH Community & voluntary sector
- Tower Hamlets residents and service

**Engagement with the public:**

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

# Newham

## 4. NEL Place based Partnership

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

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

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

**Key stakeholders:**
- ELFT
- Healthwatch
- LB Newham
- NEL ICB
- Newham University Hospital
- Primary Care
- Residents
- VCSEs

**Key programmes of work that will deliver the vision and mission**
- Joint Planning Groups (JPGs) for Babies, Children and Young People; Mental Health; Learning Disabilities and Autism (LDA); Ageing Well; Primary Care; Long Term Conditions and Urgent Care
- Local Authority-led programmes across Health Equity, Homelessness, Carers and Well Newham (prevention)
- Population growth programme – implementing our model of care based on needs of our population and capacity in the system.
- Designing an outcomes framework in partnership with residents to measure benefits and achievements

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

**Engagement with the public:**

Residents and People & Participation Leads attend Partnership Board, JPGs and project groups

# Waltham Forest

## 4. NEL Place based Partnership

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

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

**Interdependent ICB programmes**

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

**Interdependent Collaborative programmes**

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

**Key programmes of work that will deliver the vision and mission**

- Delivery of a programme of locality **prevention, wellbeing and self-care** to intervene earlier with residents to improve health outcomes dentification for intervention and support for residents with **LTCs.**
- Delivery of proactive anticipatory care through delivery of **Care Closer to Home** transformation programme and establishing **Integrated Neighbourhood teams and hubs.**
- Deliver alternative to unplanned attendances and admissions to acute hospital for adults and children and improve discharge pathways through the delivery of the **Home First programme** of transformation and improving **same day access to primary care** for all residents**.**
- To deliver priorities in our **children's health strategy** , including improving access to **therapies** and access to support for children with additional needs.
- To transform end of life (**EOL)** services in Waltham Forest to ensure residents have the support to die in their choice of place.
- Improving access to **Mental Health and** support in community for all ages and promoting positive well-being for all.
- Reduce inequalities experienced by **autistic people** and those that have a Learning Disability, ensuring that we have the right accommodation and support in place to maximise independence and ensure good health outcomes.

**Summary of the benefits/impact that north-east London local people will experience by April 2025 and April 2027:**
1 Reduce the variation in undiagnosed Long Term Conditions, 2. Improve the uptake of immunisation, 3. Improved access for resident to health and care services to support health and wellbeing in their local areas, 4. Enable people to stay well in their own homes by proactively organising and managing their care & support, 5. Reduce the need to attend / stay in hospital for residents with complex needs, 6. Ensure residents in hospital for the optimum time and are supported to rehabilitate and recover, 7. Enable people to stay well in their own homes by proactively organising and managing their care & support, 8. Improved access to community palliative care support for resident at the end of life, 9. Improve access to support and services for babies, children and young people, especially those with additional needs, 10. Improved access to MH and LDA services

**Key stakeholders:**
This plan has been developed by the WF health and Care Partnership Board, in collaboration with the Health and Well Being Board. It reflects discussion and engagement at Board and sub board multi agency and stakeholder forums and planning events held in 2023

**Engagement with the public:**
Comprehensive programme of engagement with local residents during 2023. 400 + residents and 50 + community groups involved. Insight informed the development 4 pillars of good care to be embedded into all our work programmes:
•**Trustworthy**
•**Accessible**
•**Person- centred**
•**Competent**

# City & Hackney

## 4. NEL Place based Partnership

**Portfolio vision, mission and key drivers:**
Working together with our residents to improve health and care and make City and Hackney (C&H) thrive. We want to improve health outcomes and reduce health inequalities, focusing on 3 key areas:

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

The C&H Neighbourhoods programme is about fostering community connections, at a hyper local level, and our aim is to improve quality of care, access and waiting times for all our residents particularly those experiencing Health inequalities. We apply the principles of right time, right place, right support. We acknowledge that the solution requires collaboration with wider system partners including local authorities, public health and our voluntary sector partners and residents. **Key drivers:** - National regional policy frameworks, local needs - we will target areas in C&H where we have poor outcomes and evidence of inequalities (as evidenced in JSNAs, Population Health data, etc.) We continue our work to become an anti-racist, systemic, and trauma informed partnership

**Interdependent ICB programmes**
**Start Well** – Immunisations; Maternity, hospital and community care, continuing care, SEND, Looked After Children and other vulnerable groups; LTCs; primary care. **Live Well** – Long term conditions (LTC) and Specialised Commissioning; Planned Care; Urgent and Emergency Care; Personalised Care. **Age Well** - Palliative & End of Life Care; NEL Care Home / Care Provider Forum / Network; Continuing Healthcare; NEL Carers Network. **Mental Health** (MH) - Children; Unplanned / Crisis Care; Community Care; NEL MH Delivery Group

**Interdependent Collaborative programmes**
**Babies, Children and Young People** (CYP) working with our NEL Collaboratives and the Local Maternity system (NLLMS). **Live Well –** Acute and Community Collaborative. **Age Well -** Mental Health Alliance; Primary Care Collaboratives. **Mental Health -** Mental Health Integration Committee (MHIC); Children's Emotional Health and Wellbeing Partnership; Psychological Therapies and Wellbeing Alliance (PTWA); CAMHS Alliance; Dementia Alliance; Primary Care Alliance; Hackney special interest group (SIG)

**Key programmes of work that will deliver the vision and mission**
**Start Well –** 0-25s commissioning across the ICB and Public Health; system wide approach to improving immunisations coverage with community leads as valued partners; SEND (separate City and Hackney SEND systems and governance); Systemic, Trauma and ant-racist informed transformation such as Improving Outcomes for Black CYP, upskilling the workforce in relation to Adverse Childhood Events; embedding real co-production e.g. across Preparing for Adulthood; focus on prevention and early identification of needs (improve outcomes and mitigate impact of waiting times) through system approach such as the SEND Graduated Approach. **Live Well** - Better Care Fund Partnership; Primary / Secondary Care Interface; Long Term Conditions Management. **Age Well** - Discharge Improvement Programme; Integrated Urgent Care - NEL Same Day Access Programme, Enhanced Community Response (robust provision of integrated urgent care – including primary care through Duty Doctor, urgent community response and emerging virtual wards); Robust utilisation of proactive care planning approach -1.3% of C&H Registered patients have a Universal Care Plan in place (compared with average of 0.5% for NEL and London-wide) and 99% of patients on Anticipatory Palliative Care Registers have a Universal Care Plan in place (and all have been offered). **Mental Health** - ADHD / ASD Assessment and Aftercare (All ages) – Backlog and Waiting times; Adult Talking Therapies – Integrated Pathways. Quality Improvement. Demand / Capacity and Waiting Times; Community Transformation / Continued Improvement with Neighbourhoods offer – aligning existing provision; Neurodevelopmental Pathways Review (CYP); Crisis / T3.5 Pathways Review (Including ICCS, Surge and IST); Whole System Approach (iThrive) – CYP Emotional Health and Wellbeing. **The City and Hackney Neighbourhoods Programme** - Supporting the workforce aligned to 8 Neighbourhoods and fostering community connections through: Working Together, Resident Voice at the Centre, Knowing your neighbourhood, Proactive care. Colocation and estates strategy. Personalisation Framework. Evaluation of impact. Developing local leadership.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**
All our work is aimed at improving the health and wellbeing of our local residents and reducing inequalities.
**Start Well: -** Parents/carers, families, children and young people will know how to access advice, care and support when it is needed. Improved workforce communications with residents in a systemic, trauma informed anti -racist way. Reduced risks of preventable disease outbreak due to immunisation uptake promotion. Families and Children & Young People will know how to access support and will not be dependent on a diagnosis to access help / information / support. **Live Well and Age Well: - Improved** support with any care needs following a hospital admission. Patients will know about services available and be supported to access the care they need. Patients will have increased care provided outside hospital, closer to their home, where appropriate. **Mental Health: -** Residents will experience Improved waiting times and better overall quality of care, with a focus on faster neurodevelopmental assessment; Psychological therapies intervention; improving 117 Aftercare; Wellbeing in School and Youth Hubs; Crisis Care including Crisis prevention and wellbeing. We will better meet the needs of residents who experience greater health inequalities e.g. social deprivation and serious mental illness.

**Key stakeholders:**
- Residents / Carers
- Local Authorities
- VCSE
- Homerton Hospital
- Barts Health
- Adult Social Care
- Childrens Social Care
- Hackney /CoL Education
- ELFT – CAMHS / Adults
- HUH CAMHS / Adults / Acute / Paeds
- Primary Care / GP Confed
- Voluntary sector Partners / SIG

**Engagement with the public:**
- Healthwatch
- Service-user reps
- Engagement with the public
- Advocacy Project (MHIC)
- Alliance coproduction and Participation
- Separate City of London and Hackney SEND Parent Carer Forums

# Health inequalities

## 5. Our Cross Cutting Themes

**Portfolio vision, mission and key drivers:**
Health inequalities exist between NEL and the rest of the country – for example we have particularly high rates of children with excess weight and poor vaccination and screening uptake – but they also exist between our places and communities. These inequalities are avoidable and unfair and drive poorer outcomes for our population. We want to improve equity in access, experience and outcomes across NEL. To do this we have made reducing health inequalities a cross-cutting theme that is embedded within all of our programmes and services within places and across NEL – everyone has a role to play. In light of NHS England's Statement on the Information on Health Inequalities, the ICB is collating and analysing a range of indicators across key health domains including the Core20Plus5, to better understand, measure and act upon the inequalities that exist in healthcare access, experience and outcomes within NEL. Over the coming months and years, the intention is for this data to inform and drive further action across ICS partners.

**Key programmes of work that will deliver the vision and mission**

- Dedicated health inequalities funding has been provided to each place-based partnership to lead locally determined programmes to reduce health inequalities within their local communities. These projects will be evaluated and the learning shared and showcased.
- Development of a NEL Health Equity Academy to support all people and organisations working in health and care in NEL to be equipped with the knowledge, skills and confidence to reduce health inequalities for the benefit of local people
- Implementation of a community pharmacy scheme to provide targeted pharmacist advice and free over the counter medicines for people on low incomes and experiencing social vulnerability across NEL, to support our communities in the context of cost of living pressures.
- Taking a Population Health Management (PHM) approach, led by places and neighbourhoods, will support frontline teams to identify high risk groups and identify unmet need. A PHM Roadmap has been developed for NEL and is being implemented.
- Embedding the NEL Anchor Charter, working with system partners to ensure we are measuring and creating the opportunities that being an anchor institution affords are leveraged for our local population, to address structural inequalities such as ensuring the NHS in NEL is a London Living Wage accredited employer, embedding social value in procurement process and better utilising our infrastructure to support community activation and supporting a greener, healthier future.
- Building on our successes in previous years our ICS Green Plan in year 3 is focusing on three key areas 1. taking a population health management approach to protecting communities from poor air quality, 2. building capability in our ICS workforce by providing sustainable healthcare training programme utilising a train the trainers programme that ensures a maintainable approach to up skilling the workforce that is not reliant on external funding sources; and 3. embedding the ' impact on environmental sustainability' into our procurement processes to support our aim of reducing our collective carbon footprint by 80% by 2028 and to net zero by 2040. The ICB convenes several forums that promote a multidisciplinary approach to transforming services and estates, in order to become more resilient to the threats posed by climate change.
- Improving access to primary care for health inclusion groups (homeless and refugee and asylum seekers) through safe surgery programme, supported discharge for homeless through the out of hospital care programme, supporting families in temporary accommodation, commissioning a NEL wide initial health assessment for those seeking sanctuary housed in contingency accommodation, and commissioning a needs assessment for health inclusion in NEL to identify needs for other underserved groups that require focus.
- Developing a homeless health strategy that will guide the work we do to support people experiencing homelessness across NEL and provide a framework for places to develop their own plans and address population needs.

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

- Reduced differences in health care access, experience and outcomes between communities within NEL, particularly for people from global majority communities, people with learning disabilities and autism, people who are homeless, people living in poverty, and for carers.
- Improved health life expectancy for all communities across NEL, irrespective of who you are or where you live.
- Our population receives more inclusive, culturally competent and trusted services, underpinned by robust equity data.

**Key stakeholders:**
Public health teams
Local authority departments
Voluntary and community sector
Primary care and NHS trusts
NHSE and Transformation partners
ICB

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

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

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

# Prevention

## 5. Our Cross Cutting Themes

**Portfolio vision, mission and key drivers:**
We want to increase our focus as a system on prevention of ill-health and earlier intervention. This means increasing our focus and resources 'upstream', to prevent illness in the first place. Preventive health offers need to be appropriate for all in our diverse communities and will only be effective when working across organisations and local authorities to address the wider determinants of health. In NEL we face significant challenges around preventable ill health, for example more than 40% children are overweight or obese and nearly all of our places have worse screening rates for breast, bowel and cervical cancer than England. This has an impact on health outcomes, demand for care and health inequalities, so these are key drivers for enhanced action.

**Key programmes of work that will deliver the vision and mission**

- Mobilising tobacco dependence treatment services across all of our trusts so that they are available in all inpatient, maternity and community services, and making these services sustainable for the long term.
- Alcohol care teams (ACTs) have been established at the Royal London Hospital and Homerton Hospital, and we will continue to make these services sustainable moving forwards and make the case to expand coverage to other hospitals in NEL.
- Population Health Management (PHM) is a key methodology that can be utilised as an approach using population health data as a means of targeting cohorts of our population that will benefit from focused approaches that include preventative interventions where appropriate. NEL ICB has recently employed a dedicated PHM lead who will be supporting places to deliver prevention intervention across NEL through improved population cohort analysis, intervention design and evaluation of intervention outcomes.
- Delivering equitable vaccination programmes in NEL builds on our experience during the Covid-19 pandemic and will continue to deliver according to national programmes and local need. We will work as a system to work with and target communities with low vaccination rates
- Cancer prevention, awareness and screening is a focus of the work of the NEL Cancer Alliance, who are strongly involved with active awareness campaigns targeting our local NEL population. These campaigns cover different cancers and aim to raise awareness and prevent cancer and support early diagnosis. For example, prostate, lung, breast, cervical and endometrial cancer awareness campaigns have been developed targeting population cohorts.
- Anchor Institutes are evolving across our system with all of our NHS Trusts and Local Authority Chief Executives having signed up to the NEL Anchor Charter. These are a set of principles that support using our institutions and the organisations as assets to better support out local communities. These aim to help tackle and reduce the wider determinants of health supporting prevention of ill health alongside health inequalities.
- We will deliver Long Term Condition programme collaboratively (for example cardiovascular, stroke, respiratory and diabetic related diseases) ensuring they are aligned with the national and regional programmes that focuses on entire pathways from LTCs prevention to escalations of LTC management within acute care. The NEL LTCs teams are linking in with systemwide colleagues with several key activities focused on LTC prevention and early identification.

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

- Increased smoking quits, leading to a wide range of improved health outcomes and lives saved, particularly in more deprived communities.
- ACTs support patients experiencing harm as a result of alcohol use disorders and will lead to a reduction of alcohol-related conditions such as CVD, cancers and liver disease, as well as harm from accidents, violence and self-harm.
- There is a commitment over time to increase the proportion of our budget that is dedicated to prevention and earlier interventions, this would be done concurrently to shifting the system partners have a greater focus on prevention.
- Our anchor institutions will also begin to play more of a role in tackling poverty and promoting social and economic development.
- A maturing infrastructure including population health management awareness and digital population data availability will help impact the NEL system in supporting prevention by helping to identify those population cohorts that will greatly benefit from prevention and earlier intervention services and engagement.
- NEL ICB has developed a draft Immunisation Strategy with system partners to build on the legacy of the covid vaccination programme. This will be refined in line with the National Immunisation Strategy. The ambition is to build on the digital advancements for service delivery, develop the workforce to support access for local people and embed engagement with all communities to support uptake of vaccinations across the whole life course, thereby preventing ill health.

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

**Details of engagement undertaken with Places, collaboratives and other ICB portfolios:**
Key prevention engagement related to specific programmes are well documented by each of the organisations and programmes leading on each area of work.
Central NEL ICB oversight of all prevention related engagement across all programmes and services is a challenge and therefore an alternative approach is to ensure that the system (via Places, Collaboratives and workstreams) is able to identify, scale and spread those areas of Prevention engagement which has proven successful.

**Engagement with the public:**
Key public engagement is occurring within our workstreams that encompass a preventative element. For example as mentioned Cancer and Long term conditions

# Personalised care

5. Our Cross Cutting Themes

**Portfolio vision, mission and key drivers:**
Personalised care involves changes in the culture of how health and care is delivered. It means holistically focussing on what matters to people, considering their individual strengths and their individual needs. This approach is particularly important to the diverse and deprived populations of NEL, where health inequalities have been exacerbated by the pandemic and further compounded by the cost of living increase. Embedding personalised care approaches into clinical practice and care, which take into account the whole person and address all their needs holistically will ensure our most vulnerable communities are supported in the years ahead. We have built a strong foundation for personalised care over the last three years as a system, with an early focus on social prescribing and personal health budgets. Aligned to the 'Comprehensive model of Personalised Care', our vision is to lead and enable the delivery of the six components of personalised care and embed these in local population health approaches.

**Key programmes of work that will deliver the vision and mission**

- Developing personalisation strategy for NEL that aligns with our health inequalities agenda and provides a framework for places to develop their own plans and address population needs
- Ensuring social prescribing link workers can capture the NEL social prescribing minimum dataset via a digital template and analyse the data in a PowerBI dashboard
- Expanding the implementation of Joy platform across NEL providing a directory of service platform to support same day access
- Developing personalised care workforce plans with primary care and training hubs to support the Fuller actions relating to integrated neighbourhood teams
- Support equity of offer and quality assurance of personal health budgets across NEL for the Right to Have cohorts
- Piloting new approaches to deliver personal health budgets for rough sleepers and discharge from hospital to support underserved groups and address winter planning pressures
- Developing a strategy to embed creative health in services across the system with specific focus on addressing health inequalities
- Promote supported self-management and digital enablement through Patients Know Best
- Standardise personalised care and support planning including increasing use of digital tools e.g. Patients Know Best and Universal Care Plan
- Invest in social prescribing 'community chests' to increase resources in the community and voluntary sector locally, targeted at addressing local inequalities and providing social value to our communities where it is needed most.
- Promote patient choice and shared decision making across the ICS to increase the involvement of each patient in decisions about prevention, diagnosis and their care or treatment.

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

- Local people are asked what matters to them in setting their treatment or care goals and can access a wide range of non-medical support in the community.
- Particularly vulnerable people and underserved groups are identified and given additional support to access services ensuring their experience and outcomes of care are equitable.

**Key stakeholders:**
Primary care
Place-based directors
Local authority
Public health teams
VCSE
NHSE and Transformation partners
Acute teams e.g. social prescribing & discharge

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

- NEL Population Health and Inequalities Steering Group is made up of representatives from places and collaboratives, and leads from across the ICS
- Engagement with place at the senior management group

**Engagement with the public:**

- Engagement on specific topics, and in depth at place level

# Co-production

5. Our Cross Cutting Themes

**Portfolio vision, mission and key drivers:**
People and communities have the right to participate in all aspects of our work. From the design of services to setting of budgets, from the development of strategy to being active participants in the delivery of services, and from holding us to account to shaping the measures by which our success will be defined.
We believe participation is a right because it is a right within the NHS Constitution, it is public money and therefore health and care services belong to our local people and are directly linked to their health and wellbeing. We know that by working alongside residents and communities in partnership we will together be better able to address inequalities, improve access, experience and outcomes, and that our best services are those that have been co-designed with the people who use them. Our NEL Working with People and Communities (WPC) strategy sets out our commitment to co-production and resident involvement.
Communities themselves often have the best understanding of the issues affecting them and the solutions that are needed to deliver change. As well as the benefits to the NHS, our wider partnership and our population in north east London, coproduction and resident involvement has the potential to deliver real benefits for individuals as they develop an increased understanding of services, new skills, improved confidence and a sense of being able to shape their surroundings and their own health and wellbeing.

**Key stakeholders:**
Local people
Healthwatch and other patient representatives
Voluntary and Community sector
Place Directors and clinical leads
Complaints and patient experience
Programme teams
NHS Trusts and local authorities

**Key programmes of work that will deliver the vision and mission**
- Delivery of the key commitments set out in the Working with People and Communities Strategy to provide local people with meaningful opportunities to be involved in the work of the ICS including how we spend our available funding
- Engagement and coproduction planning to support work across a specific topic or programme of work e.g. end of life care, with children and young people, maternity and women's health
- Development of partnership coproduction frameworks across all seven Place Based Partnerships
- Embed the insight provided via the Community Insight System (CIS) into transformation programme, service development and improvement in NEL.
- Work with the VCSE Collaborative to build capacity within the voluntary and community sector at both a place and NEL level
- Implement the ICB Reward and Recognition policy to invest in consistent and quality engagement activity at Place and across NEL, and work towards a consistent framework with all ICS partners

**Details of engagement undertaken with Places, collaboratives and other ICB portfolios**
Building on WPC strategy - engagement and coproduction activity including the Big Conversation, targeted engagement, and insight gathered by partners through the CIS.

**Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:**
- Local people experience improved access to services and quality of care as their experiences have helped to shape the services they receive.
- Residents and their carers or representatives feel empowered by meaningful opportunities to service improvements or transformation
- Improved health outcomes as residents build their confidence and ability to positively manage their own health and wellbeing
- Improved efficiency - listening to people's experiences of services could help maximise our limited resources
- Great transparency and confidence in the ICS and its decision on service improvement and transformation

**Engagement with the public:**
Big Conversation (summer 2023), CIS reports and specific engagement and coproduction activity

# Learning system

5. Our Cross Cutting Themes

**Portfolio vision, mission and key drivers:**

The transition to an Integrated Care System has provided an opportunity to work differently in relation to how we plan, deliver, integrate and improve our services across north east London. In developing and embedding our new system operating model, our aim is to embed research, innovation, continuous learning and quality improvement in all that we do.

As we move towards a continuous learning approach and culture, the following principles will be key for our system:

- We are well-informed – before we act, we fully consider the impact of our decisions on individual, community and system outcomes and equity drawing on both data and insights; research and evidence.
- We are responsive – we are effectively monitoring our interventions, continuously learning and taking action in a timely manner.
- We reciprocate – we robustly evaluate what we do and work together to share learning openly and without blame; valuing collaboration over competition.

We will ensure that a learning system approach and culture is threaded through the new system operating model for the ICS to support closer working and integration between partners supported by greater sharing of data and information; and through improvement in how we learn from each other and spread new and innovative ways of working.

**Key programmes of work that will deliver the vision and mission**

- Develop and deliver a learning system approach, that enables us to access learning and our local evidence base to support transformation. This will include establishing a knowledge system, developing an evaluation framework and a common methodology for learning and improvement, providing training and support to embed a learning culture.
- Design and deliver our population health approach to inform future commissioning and planning. This will include developing population health management (PHM) tools, embed learning from early pilots, developing culture, behaviour and skills around PHM and related training, and by design of an incentives model.
- Develop and deliver our research strategy to ensure that we are attracting more research in our system, that research is addressing the most important questions for our population, and that more local people can participate in research.

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

- Development of a localised evidence-base, helping us to make decisions most suitable to our context and populations.
- We use data, evidence and insights to build our understanding of our population and to drive our priorities.
- All staff consider quality improvement a key part of their role and are continually striving to improve services and outcomes for local people.

**Key stakeholders:**

Place-based directors
Collaborative directors
Portfolio directors
Quality and safety
Complaints
Strategy
Programme Management Office

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

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

**Engagement with the public:**

Engagement on specific topics, and in depth at place level

# High trust environment

5. Our Cross Cutting Themes

**Portfolio vision, mission and key drivers:**

Our health and care partnership inherits a legacy of competitive and sometimes adversarial relationships between organisations, which often do not serve local people well. This is based in part on an old financial and contractual regime that encouraged the defence of organisational interests rather than a shared view of how all partners best work together to drive improvements to health, wellbeing, and equity. NEL partners have already come together to agree on our collective ambition for improving health, wellbeing and equity as well as four design principles for our system - improving quality and outcomes; deepening collaboration; creating value and securing greater equity.

We have the opportunity to ensure that our new ways of working reflect this commitment across our whole system spanning local authorities, the community, voluntary faith and social enterprise sector and health. This includes defining how place partnerships, provider collaboratives, and NHS NEL each contribute to delivering local ambitions with all parts of the system coming together as equal partners. It also means defining the interfaces between these key building blocks of our system, and the handoffs between the types of care that they are responsible for, which our experience tells us is critical to effective delivery.

Alongside this, we need to build the environment of high trust that enables seamless delivery across pathways spanning social care, primary and community care and secondary care regardless of organisational or sector boundaries. Only building this truly collaborative and high-trust culture will enable our new partnership to work for local people and within and across local partners; without it, our new structures will have limited impact on the people of north east London.

**Key programmes of work that will deliver the vision and mission**

- Building on the work to develop a mutual accountability framework, we will continue to develop our system operating model towards greater integration as a system. This will provide increasing clarity for the system on our respective roles and responsibilities as well as developing collective agreement on how place partnerships, provider collaboratives, and NHS NEL will work together to deliver better outcomes for local people. This work will be informed by the NHSE London review of provider collaboratives that is currently underway as well as the strategic reset of the APC to incorporate areas of collaboration previously being taken forward on a Barts Health / BHRUT footprint.
- In addition, this work includes developing our population health outcomes approach to planning, commissioning and resource allocation.
- Alongside this we will continue to design and deliver the cultural and behavioural development programme which began in 23/24 with the support of an external system development partner.

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

- Local people trust our services and advice because they feel that their voices are heard and our delivery is culturally competent.
- Partners feel actively engaged in and know how best to contribute to our partnership work. We are working towards our collective ambition and can demonstrate how our agreed design principles are shaping our approach.
- Our partnership work is undertaken in a spirit of constructive engagement and shared risk, guided by the aspirations and needs of local people, with issues tackled together without blame.
- All partners adopt an open-book approach to aspirations, challenges, risks, and finances.

**Key stakeholders:**

Place-based Partnerships
Collaboratives, including the VCSE
Local Authority

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

- Early engagement started with Place and collaborative leads
- Full engagement plan to be developed to include in-depth conversation with all system partners

**Engagement with the public:**

- This is a system specific programme.
- Specific interventions will be tested and engaged with local people as required

# 6. Implications and next steps

# How will we know we have succeeded - NEL Outcomes Framework

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

**What do we mean by an outcomes framework?**

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

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

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

We will use the insight gathered through the Big Conversation, in paritcular what our residents told us is important to them about their experience and access to services, to develop our Outcomes Framework and a set of quality ambitions.

# Next steps for our transformation programmes

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

**Technical work**

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

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

**Engagement**

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

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

# We will continue to evolve as a system

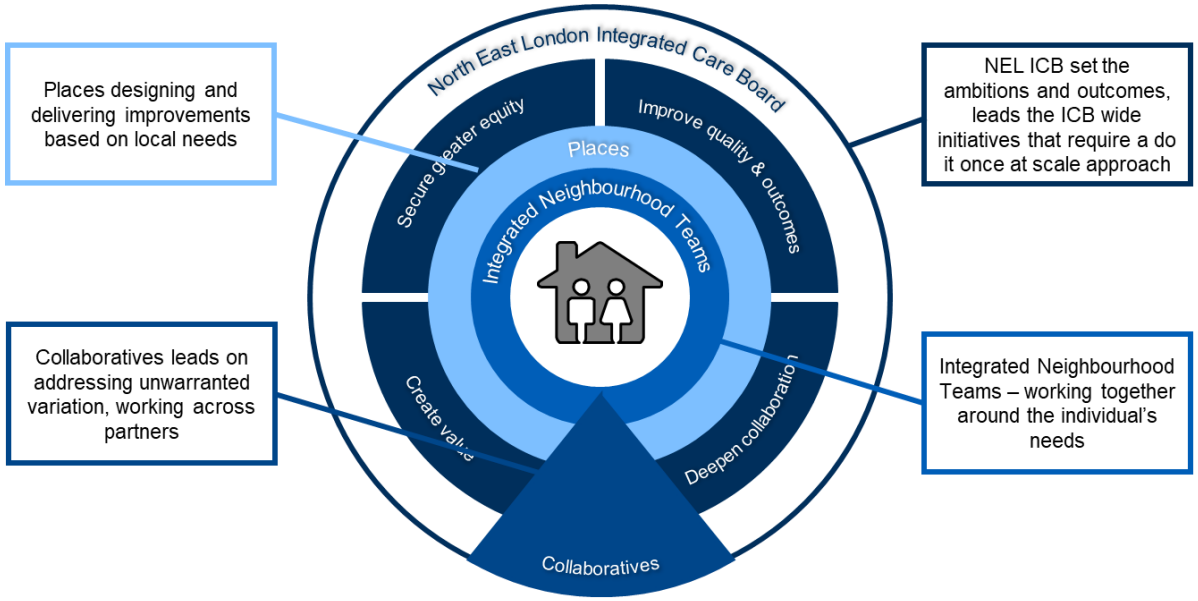
Our system has been changing rapidly over recent years, including the inception of provider collaboratives, the launch of seven place based partnerships, the merger of seven CCGs followed by the creation of the statutory integrated care board and integrated care partnership in July 2022.

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

- At **Place** delivering integrated services and improvements for Neighbourhoods and Place;
- In **Provider Collaboratives** reducing unwarranted variation, driving efficiency and building greater equity;
- For **NEL,** convening and sharing best practice, supporting greater alignment and tackling variation, providing programmatic support and oversight, and delivering enabling functions to our organisation and ICS through a business partner model.

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

- 'Pull together' in the same direction towards measurable and meaningful impact for our local population.
- Ensure that activity, transformation and engagement happens at the most appropriate level, duplication is reduced and tensions are identified and resolved
- Deliver value for money
- Deliver beneficial and sustained impact for the health and wellbeing of local people.




During 23/24 we appointed a learning partner to work with us to accelerate system development with a specific focus on providing greater clarity on roles and responsibilities, exposing the tensions and barriers holding back our progress and focusing on how we develop the behaviours to support greater integration and collaboration. We will continue this work over the coming months and years underpinned by our ambition to create a **High Trust Environment** that supports integration and collaboration and to operate as a **Learning System** driven by research and innovation.

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

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