North East London Integrated Care Board

Barking & Dagenham

Notice of Meeting

HEALTH & WELLBEING BOARD AND ICB SUB-COMMITTEE (COMMITTEES IN COMMON)

Tuesday, 16 January 2024 - 5:00 pm
Council Chamber, Town Hall, Barking IG11 7LU

Date of publication: 8 January 2024

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Membership

Name	Title	HWBB	ICB
Cllr Maureen Worby (Chair)	Cabinet Member for Adult Social Care and Health Integration, LBBD	✓	✓
Charlotte Pomery (Deputy Chair)	Executive Director, NHS North East London	✓	✓
Elaine Allegretti	Strategic Director, Children and Adults, LBBD	✓	✓
Pooja Barot	Director, Care Provider Voice		✓
Matthew Cole	Director of Public Health, LBBD	✓	✓
Selina Douglas	Executive Director of Partnerships (NELFT)		✓
Tom Ellis	Director of Strategy, Newham University Hospital	✓	
Cllr Syed Ghani	Cabinet Member for Enforcement and Community Safety, LBBD	✓	
Jenny Hadgraft	Interim Healthwatch Manager, B&D Healthwatch		✓
Dr Ramneek Hara	Clinical Care Director, NHS North East London	✓	✓
Ann Hepworth	Director of Strategy and Partnerships, BHRUT	✓	✓
Louise Jackson	Chief Inspector, Metropolitan Police	✓	
Cllr Jane Jones	Cabinet Member for Children's Social Care and Disabilities, LBBD	✓	
Cllr Elizabeth Kangethe	Cabinet Member for Educational Attainment and School Improvement, LBBD	✓	
Sharon Morrow	Director of Partnership Impact and Delivery Barking and Dagenham, NHS North East London	✓	✓
Elspeth Paisley	Health Lead, BD Collective	✓	✓
Dr Kanika Rai	Place based Partnership Primary Care, Development Clinical Lead		✓
Dr Shanika Sharma	Primary Care Network Director – West One		✓
Nathan Singleton	Chief Executive, Healthwatch - Lifeline Projects Ltd	✓	
Fiona Taylor	Chief Executive (Place Partnership Lead), LBBD	✓	✓
Sunil Thakker	Director of Finance or nominated rep, NHS North East London		✓
Chetan Vyas	Director of Quality or nominated rep, NHS North East London		✓
Melody Williams	Integrated Care Director, NELFT	✓	

Non-voting members

Craig Nikolic	Chief Operating Officer, Together First CIC, B&D GP Federation	✓	
Dr Uzma Haque	Primary Care Network Director, North	✓	
Dr Deeksha Kashyap	Primary Care Network Director, North West	✓	
Dr Jason John	Primary Care Network Director, New West	✓	
Dr Afzal Ahmed	Primary Care Network Director, East	✓	
Dr Natalya Bila	Primary Care Network Director, East One	✓	
Dalveer Johal	NEL Local Dental Committee Representative	✓	
Shilpa Shah	NEL Local Pharmaceutical Committee Representative	✓	

Standing Invited Guests

Cllr Paul Robinson	Chair, Health Scrutiny Committee, LBBD	✓	
Andrea St. Croix	B&D Independent NHS Complaints Advocate	✓	
Narinder Dail	Borough Commander, London Fire Brigade	✓	
Anju Ahluwalia	Independent Chair Local Safeguarding Adults Board, LBBD	✓	
Vacant	London Ambulance Service	✓	
Vacant	NHS England, London Region	✓	

AGENDA

1. **Apologies for Absence**

2. **Declaration of Members' Interests**

   In accordance with the Council's Constitution and the ICB Sub-Committee's Terms of Reference, Members of the Committees in Common are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. **Minutes - To confirm as correct the minutes of the meeting on 7 November 2023 (Pages 3 - 7)**

4. **Barking and Dagenham Winter Planning Update (Pages 9 - 19)**

5. **NEL Joint Forward Plan 2024/25 Refresh (Pages 21 - 90)**

6. **ICB Finance Overview - Month 7 2023/24 (Pages 91 - 106)**

7. **Draft Annual Report of the Director of Public Health 2022/23 (Pages 107 - 199)**

8. **Barking and Dagenham Partnership Risk Register (Pages 201 - 205)**

9. **Questions from the public**

10. **Any other public items which the Chair decides are urgent**

11. **To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.**

    Private Business

    The public and press have a legal right to attend Council meetings such as the Health and Wellbeing Board, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). ***There are no such items at the time of preparing this agenda.***

12. **Any other confidential or exempt items which the Chair decides are urgent**

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Barking & Dagenham

Our Vision for Barking and Dagenham

ONE BOROUGH; ONE COMMUNITY; NO-ONE LEFT BEHIND

Our Priorities

- Residents are supported during the current Cost-of-Living Crisis;
- Residents are safe, protected, and supported at their most vulnerable;
- Residents live healthier, happier, independent lives for longer;
- Residents prosper from good education, skills development, and secure employment;
- Residents benefit from inclusive growth and regeneration;
- Residents live in, and play their part in creating, safer, cleaner, and greener neighbourhoods;
- Residents live in good housing and avoid becoming homeless.

To support the delivery of these priorities, the Council will:

- Work in partnership;
- Engage and facilitate co-production;
- Be evidence-led and data driven;
- Focus on prevention and early intervention;
- Provide value for money;
- Be strengths-based;
- Strengthen risk management and compliance;
- Adopt a “Health in all policies” approach.

The Council has also established the following three objectives that will underpin its approach to equality, diversity, equity and inclusion:

- Addressing structural inequality: activity aimed at addressing inequalities related to the wider determinants of health and wellbeing, including unemployment, debt, and safety;
- Providing leadership in the community: activity related to community leadership, including faith, cohesion and integration; building awareness within the community throughout programme of equalities events;
- Fair and transparent services: activity aimed at addressing workforce issues related to leadership, recruitment, retention, and staff experience; organisational policies and processes including use of Equality Impact Assessments, commissioning practices and approach to social value.

MINUTES OF
HEALTH & WELLBEING BOARD and
ICB SUB-COMMITTEE
(COMMITTEES IN COMMON)

Tuesday, 7 November 2023
(5:01 - 6:52 pm)

Members Present: Cllr Maureen Worby (Chair), Charlotte Pomery (Deputy Chair), Elaine Allegretti, Pooja Barot, Matthew Cole, Tom Ellis, Cllr Syed Ghani, Dr Ramneek Hara, Ann Hepworth, Cllr Jane Jones, Manisha Modhvadia, Sharon Morrow, Elspeth Paisley, Dr Kanika Rai, Dr Shanika Sharma and Fiona Taylor

Invited Guests, Officers and Others Present: Andrea St. Croix, Brid Johnson, Jenny Hadgraft, Christine Brand, Fiona Russell, Susanne Knoerr, Sarah Carter, Debbie Harris and Alan Dawson

Apologies: Selina Douglas, Nathan Singleton, Sunil Thakker, Melody Williams and Anju Ahluwalia

22. Declaration of Members' Interests

There were no declarations of interest.

23. Minutes (19 September 2023)

The minutes of the Health and Wellbeing Board and ICB Sub-Committee meeting held on 19 September 2023 were confirmed as correct.

24. Barking and Dagenham Safeguarding Adults Board Annual Report 2022/23

Councillor Worby presented the Barking and Dagenham Safeguarding Adults Board (SAB) Annual Report for 2022/23 on behalf of the Independent Chair of the SAB who was unable to attend the meeting.

Councillor Worby referred to the role of the SAB, its close relationship with the three statutory partners of the Council - the NHS North East London Integrated Care Board (NEL ICB) and the Police - and the key achievements of the SAB and its three committees during 2022/23. The SAB had established the following six main priorities for 2022/23, which were each supported by a range of actions:

1) Support for Hoarding and Self Neglect;
2) Implement a Learning and Development Committee to deliver joint multi agency learning;
3) Preparing for CQC regulation;
4) Joining up with children's social care on key cross cutting themes;
5) Develop governances, safeguarding and quality interfaces with NEL ICB;
6) Develop a community safeguarding offer and preventative offer for adults.

The Annual Report included data on enquiries under Section 42 of the Care Act 2014 relating to individuals experiencing, or at risk of, abuse and neglect. The data showed that Barking and Dagenham received 1,511 adult safeguarding

concerns in 2022/23, 252 of which (17%) led to a Section 42 enquiry. Councillor Worby welcomed the relatively low level of referrals that resulted in a Section 42 enquiry, which also compared favourably with the overall national rate of 30%. However, she did express a slight concern at the low level of referrals from agencies such as the Police and also remarked upon a disproportionate level of white adults being referred in comparison to other ethnic groups, which suggested that more targeted information was needed to raise awareness amongst minority ethnic groups. A further observation was made relating to the low level (3%) of domestic abuse-related referrals.

In response to a question regarding the Police's priorities around safeguarding, Councillor Worby confirmed that the local Police were an active member of the Borough's Community Safety Partnership (CSP) and took shared responsibility for safeguarding. It was acknowledged, however, that the recent position taken by the Metropolitan Police regarding responses to mental health-related 'crisis' incidents was a cause for concern, particularly in terms of the added pressure that may have on other parts of the overall system, such as health providers and local authorities. Other issues raised during the discussions included:

- The increasing number of hunger-related cases being experienced;
- The need for robust transitional arrangements for young people turning 19 years of age who move from children's social care services onto adult social care;
- The importance of using meaningful language when communicating on 'safeguarding' issues, so that the entire local community, including minority ethnic groups, can understand what safeguarding means for them and their families, the various types of abuse that can be experienced such as financial abuse and 'cuckooing', the support services available and the experience that they can expect;
- The particular vulnerabilities amongst the 18-25 year old group, many of whom were not known previously known to Children's social care;
- The "integrated front door" multi-agency project being developed amongst partner organisations.

Summarising the discussions, Councillor Worby called on all partners to proactively use the information in the SAB's report and the issues raised at this meeting to contribute to a system-wide response to support vulnerable adults. In that regard, she agreed to discuss with the Independent Chair of the SAB the development of an action plan. Dr Sharma also referred to the health inequalities work being led by the Primary Care network, citing examples of drop-in centres and youth pop-up clinics, which could form part of a Borough-wide action plan.

The Health and Wellbeing Board and ICB Sub-Committee **resolved** to note the Safeguarding Adults Board (SAB) Annual Report 2022/23 at Appendix 1 to the report.

25. System Planning Cycle 2024/25

Sharon Morrow, Director of Partnership, Impact and Delivery, NEL ICB, introduced a report on the refreshing of the Joint Forward Plan (JFP) for 2024/25, which incorporated local plans in the areas of (1) long term conditions; (2) obesity and smoking; (3) the best start in life; (4) ageing well; and (5) estates.

The JFP acted as a delivery plan for the integrated care strategy of the local Integrated Care Partnership (ICP) and relevant joint local health and wellbeing strategies (JLHWSs), whilst addressing universal NHS commitments. It had been developed by the B&D ICB together with the Barking, Havering and Redbridge University Trust (BHRUT) and the North East London NHS Foundation Trust (NELFT).

Ms Morrow acknowledged that more work was needed to align the planning process with the financial recovery plan, to understand and mitigate risk and to develop a system approach to prioritisation. Various measures had already been put in place and a new partnership Planning Steering Group had been established to guide partners through the process, linking to current strategies and the priorities of the various organisations. The approach to refreshing the plans for 2024/25 would focus on three key areas of reflection, local insight and resource requirements and a further report would be brough back to the Committees in Common early in the New Year.

Members spoke in support of the approach but it was stressed that a fundamental role of the Committees in Common was to assess the impact of plans and strategies. To that end, understanding how all of the plans and strategies interacted with each other was crucial and Members discussed how that could be achieved and the various factors that would need to be taken into account to deliver at the 'Place' level. It was noted that the February 2024 Committees in Common development session would focus on what had been delivered in 2023/24 for the local plans, the lessons that had been learnt and the key deliverables and targets going forward.

The Health and Wellbeing Board and ICB Sub-Committee **resolved** to:

(i) Endorse the approach to reviewing local plans; and

(ii) Note the reporting and governance timelines.

26. Business Case - Additional Capacity in Children and Young Peoples Therapy Services

Elaine Allegretti, LBBD Strategic Director, Children and Adults, presented the proposed business case that had been developed to support the enhancement of therapy services for children and young people within Barking and Dagenham.

NELFT undertook a therapy demand and capacity review in Barking and Dagenham in 2022/23, initially focused on speech and language therapy (SLT) and then expanded to include occupational therapy and physiotherapy. The Strategic Director explained that improving access to therapy support had been identified as a priority due to the significant increase in the number of children and young people on Education, Health and Care plans (EHCP), which was exacerbated in Barking and Dagenham due to it having the fastest growing child population in the country at approx. 30%, a high 18-25 year old cohort and the levels of deprivation. The combined impact of those factors meant that there was a significant deficit in therapy capacity to meet current and future demand, resulting in high caseloads and long waiting times for therapy support, particularly speech and language therapy.

The outputs of the SLT demand and capacity review fed into the ICB financial planning process for 2023/24 and growth funding of up to £500,000 was ear-marked, subject to the approval of the NHS North East London Investment Committee. The business case identified a capacity gap of 10 SLT therapists and four occupational health practitioners and physiotherapists, requiring recurrent additional funding of £923,797.

Members discussed the problems associated with recruiting to posts with high caseloads, the disparity between inner and outer London pay rates and the need for early intervention to help reduce future demand pressures. It was also suggested that the service could be enhanced by having greater links with other activities taking place in the local community to improve accessibility and support the likely success of the business case application. Tom Ellis, Director of Strategy at Newham University Hospital, referred to past experience of successful business case submissions and suggested that the demand and capacity model used in the business case should be supported with greater insight into the assumptions used and the anticipated reduction to wait times etc..

Officers were also asked to present information to a future meeting on current waiting times for therapeutic services, to assess the effectiveness of the additional resources and the impact on waiting times.

The Health and Wellbeing Board and ICB Sub-Committee **resolved** to endorse the Additional Capacity in Children and Young Peoples Therapy Services business case at Appendix A to the report, subject to the issues raised at the meeting, and recommend its approval to the NHS North East London Investment Committee.

27. Feedback from the Committees in Common Development Session 26 October 2023: Localities Working - Developing the Footprints

Sarah Carter, LBBD Head of Borough Partnerships, provided a summary of the discussions at the Committees in Common Development Session held on 26 October 2023, which focussed on the issue of “Localities Working – Developing the Footprints”.

At present, there were three recognised localities across Barking and Dagenham relating to the organisation of health and wellbeing services, roughly divided into East, West and North. It had previously been recognised that the scale of residential development in the Borough, particularly the southern part, would necessitate a review of those locality arrangements and the recent Development Session discussed some of the practical arrangements for creating that fourth locality. The session was well attended by partners and six main principles were agreed:

1) To be people-centred, ensuring that the local community was at the heart of what we do;
2) To base decisions on data and insights;
3) To provide an equity of offer, driving out unwanted variations but recognising that one size would not fit all;
4) To be efficient, ensuring that we are working as close as possible to the population to make change;
5) To be collaborative, develop trustful relationships and seek to understand

one another's challenges;
6) To have a positive attitude to change.

The Head of Borough Partnerships added that, to take those discussions forward, it was also proposed to the establish a time-limited task and finish group to determine whether it was now appropriate to create a fourth locality footprint in the south of the Borough.

Arising from the discussions on the issue, a number of observations were made which included:

- The potential need to readdress which Council wards sat in each locality if we were to move from three to four localities, acknowledging that Primary Care and GP practices would not sit neatly into localities;
- Community-based localities should be factored into the discussions;
- The need to continue to lobby for additional funding and resources to support the Borough-wide growth;
- That partner organisations may need to split current teams to co-locate into a logical area;
- That the locality discussions represented one of the early stages of meeting expectations for locally-based services over the next few years;
- The need to take account of cross-borough issues, workforce challenges and high caseloads when considering how to bring services 'closer to home'.

The Chair encouraged attendees to contact Fiona Russell, LBBD Director of Care, Community and Health Integration, to register their interest in participating in the proposed task and finish group.

The Health and Wellbeing Board and the ICB Sub-Committee **resolved** to agree the establishment of a time-limited task and finish group to determine whether to create a fourth locality footprint in the south of the borough.

28. Questions from the public

There were no additional questions from the public.

29. Any other business

The Chair referred to a flyer that had been circulated at the meeting relating to free training workshops aimed at helping identify 'hidden' carers, how to support them and accessibility to the Carers' Hub, and encouraged attendees to share the information within their organisations.

The Chair also asked officers to report to the next meeting on the challenges currently being faced by the London Ambulance Service and their impact on response times across Barking and Dagenham and other knock-on effects.

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North East London
Integrated Care Board

Committees in Common of ICB Sub-Committee and Health and Wellbeing Board

16 January 2024

Title of report	Barking and Dagenham Winter Planning Update
Author	Kelvin Hankins, Deputy Director / Lead for Ageing Well, Barking and Dagenham Place Team, NEL ICB
Presented/Sponsored by	Kelvin Hankins, Deputy Director / Lead for Ageing Well, Barking and Dagenham Place Team, NEL ICB
Contact for further information	Kelvin Hankins Kelvin.Hankins@nhs.net
Wards affected	All
Key Decision	No
Executive summary	The report details progress made in the mobilisation of the Barking and Dagenham Place Winter Plan, at the midway point in the winter period. The report also includes an overview of key performance metrics during the winter period, which shows that despite a difficult and pressured winter performance has been strong with an improvement in access targets in urgent and emergency care across hospital sites and community urgent treatment centres. There have also been improvements in ambulance handover waits at hospital sites, although the system recognises that there is further transformation required. Implementation of the winter plan has gone well with the majority of actions on course or completed, in particular support on the respiratory pathways have seen dedicated support to children and young people who asthma and the commissioning of the Respiratory Hubs starting week commencing 8th January 2024. The winter communication plan has gone live, through a range of mediums and targeted campaigns to particular communities.
Action / recommendation	The Board/Committee is asked to discuss and note the contents of this report
Reasons	Not applicable
Previous reporting	An earlier version of the report was discussed at the Barking and Dagenham Executive Group.
Next steps/ onward reporting	Not applicable
Conflicts of interest	None as no decisions are required.

Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The report detailed progress made on implementing the Barking and Dagenham Winter Plan, this includes detailing the actions and support provided to residents.
Impact on finance, performance and quality	There are no financial decisions required in the report. The report details highlighted performance of emergency care system over winter.

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1 In September 2023 the Barking and Dagenham Committees in Common approved the Barking and Dagenham Place Winter Plan for 2023/24. This paper details progress made in implementing the plan, highlighting any changes since the plan was approved and detailing any new risks. The plan identified three priority groups to focus:

- Children (0-4) and families
- People with respiratory disease (adults and children)
- People with multi-morbidities accessing integrated case management

Alongside the three priority groups we have also launched the NEL Winter Communication Plan.

1.2 The aim of the winter plan is to support residents and staff during the winter period through agreeing the actions that are taken to retain resilience and accommodate surges in activity above anticipated winter pressures.

1.3 A further impact during this winter has been the series of industrial action, which have resulted in increased pressures on the system to ensure resident care and support during these times. Including industrial actions on the 2nd to 5th October, 20th to 23rd December and 3rd to 9th January.

1.4 The committee asked to discuss and note the contents of this report.

2.0 Performance

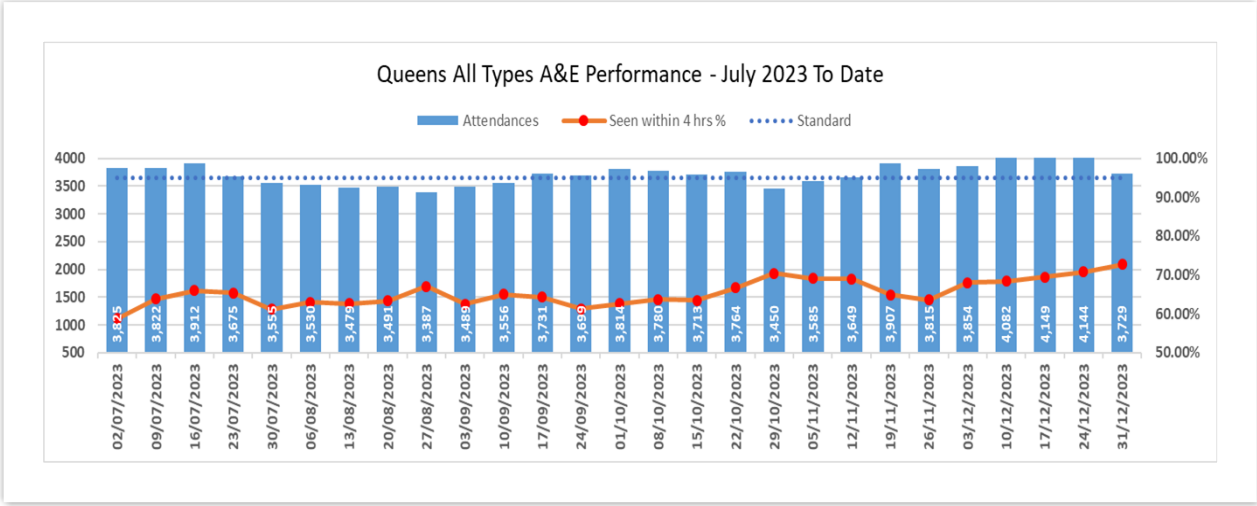
2.1 Barking and Dagenham residents access urgent and emergency services in a range of locations within North East London. The main acute hospitals are Queens Hospital, King Georges Hospital and Newham University Hospital, with Urgent Treatment Centres at all three sites and the Barking Hospital site.

2.2 This paper will detail the performance for the above services using the nationally set standards for urgent and emergency care. Please note that the national commitment is for 95% of attendances to be seen within 4 hours at an attendance

to an emergency department, as part of COVID recovery the NHS Operating Plan has made the requirement for emergency departments to deliver 76% of attendees seen within 4 hours of arrival, this is across all types of attendances and would include the Emergency Department and the Urgent Treatment Centre. The graphs in this pack monitor against the 95% standard.

2.3 Queens Hospital

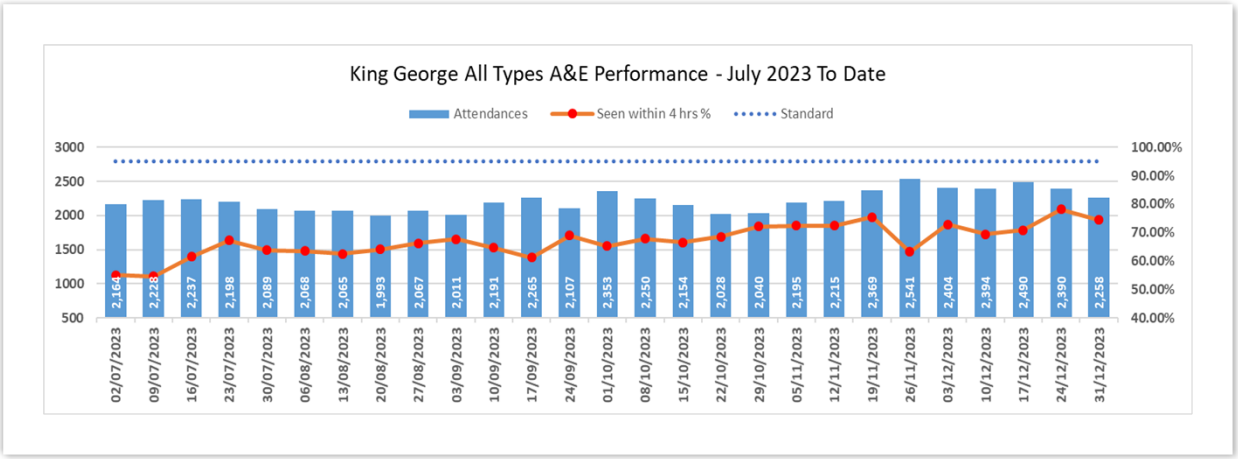
Performance at Queens Hospital has improved in December 2023 with an average of 70.55% of people seen within 4 hours, which is a significant improvement on the same time last year, this is against an increase in attendances during the winter period.



Queens	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD for completed months
2023/24 Monthly Actual Performance %	61.25%	62.98%	61.03%	63.91%	63.98%	63.23%	66.26%	65.99%	70.55%				**64.38%**
2022/23 Monthly Actual Performance %	59.56%	58.98%	58.79%	59.75%	58.31%	61.03%	60.20%	57.57%	54.82%	60.16%	54.75%	57.52%	**58.43%**

2.4 King George Hospital

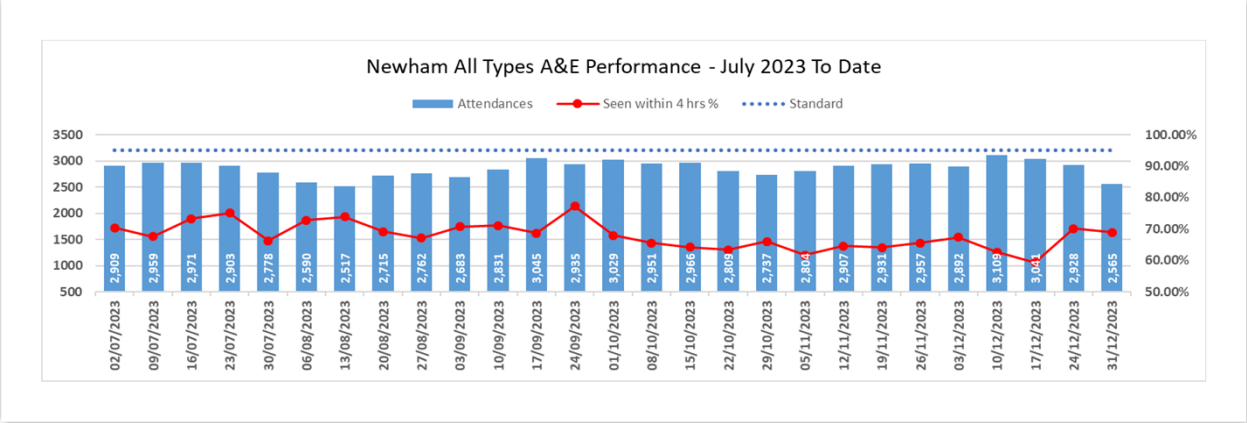
Performance at King George Hospital has also improved in winter with 72.72% of patient seen within 4 hours, this is also a significant improvement on this time last year, and is the highest performance in the last two financial years.



King George	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD for completed months
2023/24 Monthly Actual Performance %	58.14%	50.43%	55.00%	61.74%	64.45%	65.40%	68.78%	71.43%	72.72%				**63.16%**
2022/23 Monthly Actual Performance %	57.23%	57.95%	55.74%	55.26%	59.18%	55.88%	53.71%	54.59%	51.88%	55.62%	55.73%	53.90%	**55.47%**

2.5 Newham University Hospital

Performance at Newham University Hospital has slightly deteriorated in December 2023- however has improved on this time last year.

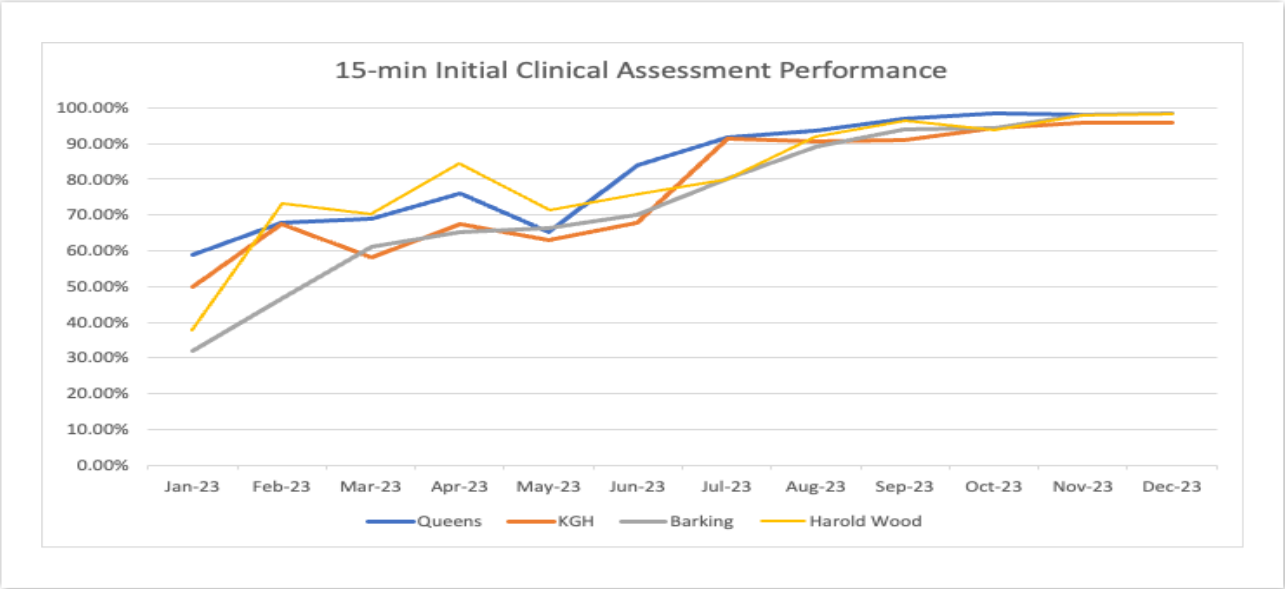


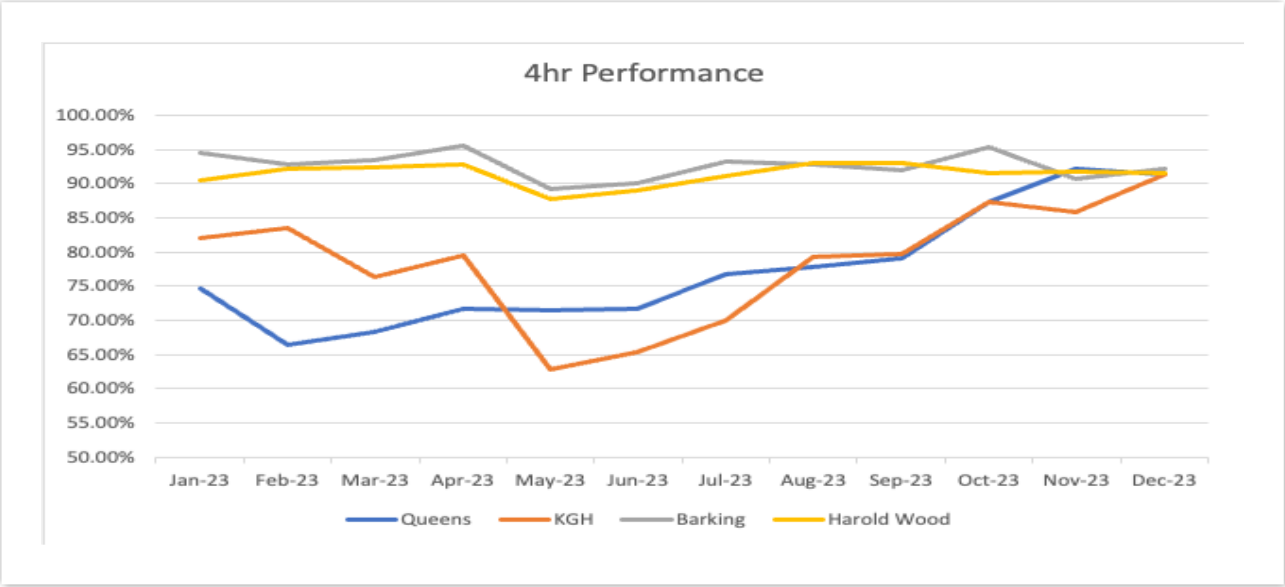
Newham	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD for completed months
2023/24 Monthly Actual Performance %	75.62%	68.75%	70.73%	70.53%	70.27%	71.63%	64.57%	64.38%	65.64%				**69.06%**
2022/23 Monthly Actual Performance %	70.80%	70.26%	70.56%	71.79%	70.54%	71.26%	67.85%	64.35%	59.89%	70.89%	66.27%	70.91%	**68.70%**

2.6 Barking Hospital Urgent Treatment Centre and wider Urgent Treatment Centre

Urgent Treatment Centres are required to meet the same performance standards as Emergency Department, due to the lower level of complexity to emergency departments there is an expectation that 95% of patients are seen within 4 hours. In Barking and Dagenham, Havering and Redbridge Urgent Treatment Centres are provided by PELC.

There has been a significant improvement in performance across the urgent treatment centres, including at Barking Hospital. Over 90% of patients attending have an initial clinical assessment within 15 minutes of arrival. There has also been a significant improvement in the 4-hour performance in particular at the Queens and KGH sites, as the urgent treatment centres are collocated with the emergency department at the two sites the performance is also reflected in the site performance detailed above.





3.0 Ambulance Performance during Winter

3.1 Priorities for our residents and patients

National Plan - In 2022/23, the national recovery plan identifies that more than 4000 hours per day were lost nationally to handover delays during the winter period. Contribution in longer handovers included A&E waiting times in addition to staff sickness and wellbeing and patient complexity for the crew's work resulting in longer response times.

In addition to additional beds (5000 nationally) and managing sickness, 800 new ambulances were planned for commission, 100 mental health vehicles with support in specific areas including mental health crisis plans. Integrated Care Systems to identify rapid access to clinical advice and services, including a single point of access, simple route for referrals to hospital, clinical assessment in every ambulance centre. This to enable patients are referred to the right service first time including A&E departments, same day emergency care facilities, urgent care

response, urgent treatment centres, General practitioners, pharmacists and virtual care.

3.2 Ambulance Constitution- Response Times

There are national targets to ensure responsiveness for patients awaiting ambulance care which are separated into designated categories;

- **Category one:** for life-threatening injuries and illnesses, specifically cardiac arrest. These will need to be responded to in an average time of seven minutes.

- **Category two**: for emergency calls, such as stroke patients. These will need to be responded to in an average time of 30 minutes.

- **Category three**: for urgent calls such as abdominal pains, and which will include patients to be treated in their own home. These will be responded to at least nine out of 10 times within 120 minutes.

- **Category four**: less urgent calls such as diarrhoea and vomiting and back pain. Some of these patients will be given advice over the telephone or referred to another service such as a GP or pharmacist. These less urgent calls will be responded to at least nine out of 10 times within 180 minutes.
- HCP/IFT – Health Care Practitioner request or inter facility transfer

National Recovery and Winter Plan priorities

- Category 2 call response to our residents and patients is an average of **43 minutes was reported against 34 minutes in November 2023** London ambulance plan. (National target is to achieve an average of 30 mins across the year).

- Handover of patients between ambulance service and A&E should take place within 15 minutes and no longer than 30 minutes - **In November North East London reported 64.1% handover within 30 mins, with 98.4%** patients were handover over within 60 minutes.

- Validated December data has not been published yet.

3.3 North East London Ambulance Initiatives

- In 2022/23 North East London expanded the Remote Emergency Access Coordination Hub (REACH) system across Barts Health and BHRUT Trusts to seek support in conveying patients to the right place, first time. This resulted in lower conveyances for patients managed though the REACH process, with only 29% subsequently conveyed to hospital as a result of the senior clinical assessment.

- We implemented the W45 system in July 2023 to enable crews to handover patients within 45 minutes, and free crews to care for other calls waiting. We saw an 8% reduction in Category 2 response times during this time, however cat 2 response times are still challenging for London Ambulance.

- We regularly monitor handover performance to achieve national and local standards so as to minimise turnaround times and increase ambulance availability for response. This includes both London Ambulance and East of England services, the latter conveying to Whipps Cross and Queens Hospital.

- London Ambulance service is working with crews to further develop teams structure rotas, productivity and practices in recording handover.

- North East London continue to develop our approach through a clinically led ambulance conveyance group, taking action to improving clinical assessment via 111/999 and access to services such as REACH/Rapid Response/ Same Day Emergency Care /same day access.

- For 2024/25 we will continue to jointly review with trusts and ambulance services our models of care to review and build on our REACH model and other services.

4.0 Progress of agreed actions

4.1 Actions within the winter plan cover from October 2023 through to March 2024, not all aspects were to take place from the start date and some areas have actions taking place during the start of 2024.

4.2 Children and Young People

The aim of the children and young people section of the winter plan was to prevent unnecessary attendances and/or admissions to hospital through taking a proactive approach. There are no risks identified within the delivery of the children and young people actions with all being on course. The key highlights are:

- Optimise uptake of the MMR and flu vaccines
    - A dedicated Task and Finish group was put in place, chaired by the Director of Public Health
    - Increased the number of vaccination clinics to four in Barking and Dagenham
    - Vaccination UK are targeting “missing” children and young people from the list.
- Asthma and allergy friendly school co-ordinator funded jointly by the ICB and Local Authority

- The Children and Young People Hospital at Home service is due to launch in January 2024. The service is comprised of medical and nursing staff which support individuals in their own home who would normally be in a hospital bed.

4.3 People with respiratory disease (adults and children)

The aim of the respiratory disease winter actions was to take a proactive primary and community service approach to identifying and supporting residents who are at high risks of exasperation of their condition during winter.

- Children and Young People
    - The CYP Asthma nurses have been working with practices to identify patients through utilising data on admissions that are coming from acute

hospitals and cross referencing with practices. The clinical team contact patients identified and undertake a review of their asthma care plan. The programme also includes an element of education to ensure sustained post Asthma Team intervention.

- Work is also ongoing with Together First CIC to ensure all admission data is triangulated and vulnerable children are targeted.

- Adults
  - A review of various data sources is currently being undertaken, similar to children and young people actions, to identify adults that would benefit from an enhanced review of their care and treatment plan. The data is being reviewed and managed through joint working between Together First and NELFT Community Respiratory Team.

  - A programme of work is ongoing between the ICB Medicines Management Team and Together First CIC to ensure that appropriate residents have rescue packs, reducing inappropriate issuance and appropriate residents have the packs, this is being achieved through using validated data and linking with community teams.

- Respiratory Hubs
  - A key pillar of the Barking and Dagenham Winter Plan has been the need for Community Respiratory Hubs, to support residents who need urgent access to care and treatment but don't need to attend an emergency care setting.

  - NHS England's National Winter Plan detailed the requirement for systems to have respiratory hubs in place during the winter period. In 2022/23 these were funded by NHS England however this year national funding was not available. The Barking and Dagenham Partnership identified funding a small underspend in other budgets to enable hub activity to be commissioned between January 2024 to March 2024, the coldest period of the year when exasperations are at their highest.

  - The hubs aim to reduce activity within Urgent Treatment Centre, Emergency Departments and Primary Care. They are bookable by staff in Urgent Treatment Centres, 111 and Primary Care against the criteria.

  - An average of 2,909 appointments over the 3-month period have been made available with the expectation that a minimum of 65% are delivered face to face. The activity has been commissioned via the PCNs, to be delivered as part of the existing Same Day Access Hubs. In Barking and Dagenham, the PCN's subcontract Together First CIC to provide the service.

4.4 **People with multi-morbidities accessing integrated case management**

The aim of this section of the plan is to support the promotion of Integrated Case Management, ensure that Falls Prevention Service are maximised and pilot new approaches to proactive care.

Integrated Case Management – A review of data, of which practices use the service and identify areas of low utilisation to understand this better was undertaken in addition to a workshop held with one PCN to identify areas for improvement. The workshop also informed the proactive care pilot. During January we are intending to promote the service to practices through education events and a targeted approach to particular practices.

Falls Prevention – In November a small workshop was held with all fall's services in Barking and Dagenham to identify immediate actions we could take to better support our residents who are at risk of falling. The workshop identified that we have a range of services inline with best practice however we have a very reactive model that responds when somebody has fallen, a shift is required to a more proactive prevention model. A wider system workshop is scheduled for the 12th January to develop a new model and approach. In the mean time we have promoted NELFT Falls Service to Primary Care and Care Homes through pre-New Year communications.

Pilot Proactive Care – Post the Integrated Care Management workshop a pilot has been developed with West One PCN, the aim of the pilot is to develop a proactive approach to identify high risk residents and provide individualised care and support through a multi-disciplinary team approach. The pilot was due to go leave in late December, however due to pressure in the system has been pushed back to the start of February with a launch workshop taking place in mid-January with all the teams involved.

4.5 In addition to the above there have also been key areas, which support the winter plan, that have been agreed which were not included within the original winter plan.

North East London selfcare advice service from community pharmacy for socially vulnerable residents
The Selfcare Advice Service will provide local residents with clinical advice for managing their minor ailments or signpost to other integrated services which form part of the community pharmacy clinical framework e.g. hypertension case-finding, smoking cessation, or pharmacy contraceptive services. It will also provide additional benefit by confirming community pharmacies as accessible clinical services for residents, providing health advice, supporting health promotion and the prevention of ill-health and providing links to other local services including immunisations. Funding has been agreed, launch date to be confirmed which may be after winter.

Barking and Dagenham Reablement Service
As part of the Tier 1 arrangements in North East London Barking and Dagenham were successful in receiving funding to launch and pilot a Reablement Service, support residents being discharged from hospital or requiring support in their own home to maximise their independence and reach goals. The service is currently in the process of mobilising with aspects having gone live in December, with rapid mobilisation.

Respiratory Virtual Ward
A pilot of the Respiratory Virtual Ward has been agreed across BHR boroughs. The intention is for the ward to support people who would normally be in an acute bed but can be managed in the community under the care of a specialist service.

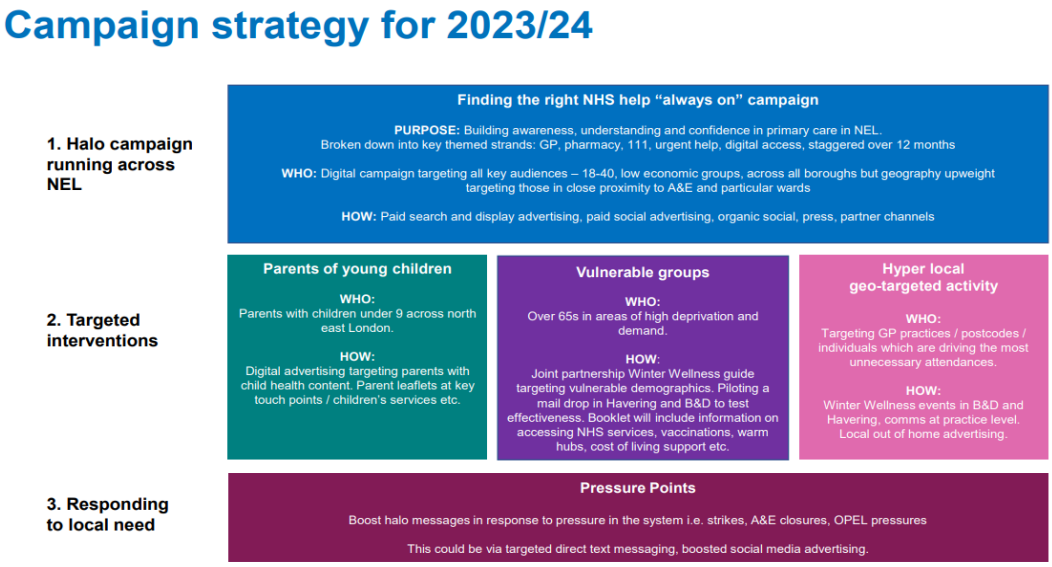
NELFT are leading the service working with partners. Funding has been agreed, initial launch date confirmed for February 2024, however the service has soft launched in December to support in winter through early support discharge for particular patients.

MiDOS

MiDOS is an electronic directory of services, used by Primary Care, London Ambulance, Emergency Departments and 111 to identify health and care services, including the voluntary sector. In preparation to winter a review of the directory for Barking and Dagenham has been undertaken with a complete update to ensure the directory reflects local services.

4.6 **Winter Communication Plan**

As detailed within the Winter Plan a wide-ranging communication plan, which will be run all year, has been launched to support residents on navigating health and care services. The plan has been developed into three sections:



Update:

- The digital advertising campaign launched 20th November across all boroughs and running for 12 months.

- NHS NEL Communication Team are working with B&D Council on our joint winter wellness guide, which went to every household in December.

- Out of home advertising is now live in B&D across the council's digital screens promoting:
    - Route to urgent help,
    - Urgent GP appointments available 7 day a week,
    - Mental health crisis lines,
    - GP registration.

- Press releases went to all local newspapers promoting access to NHS services out of hours over Christmas period, and encouraging things like stocking up on over the counter medicines and prescriptions.

- Winter Wellness and Guide for Parents flyers distributed at community Antenatal and GP led Pop Up clinics.

5.0 Risks and mitigations

5.1 Risks are detailed within the report with ongoing pressure in the system, impacted further by industrial action, however actions detailed within the winter plan have been or in the process of being implemented. There are no specific risks identified with the delivery of the winter plan actions.

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North East London
Integrated Care Board

Committees in Common of ICB Sub-Committee and Health and Wellbeing Board

16th January 2024

Title of report	NEL Joint Forward Plan 2024/25 Refresh
Author	Anna Carratt, Deputy Director of Strategic Development NHS NEL
Presented/Sponsored by	Sharon Morrow, Director of Partnership, Impact and Delivery, NHS NEL
Contact for further information	Anna Carratt, Deputy Director of Strategic Development, a.carratt@nhs.net
Wards affected	All
Key Decision	No
Executive summary	This report provides an update on the system planning for 2024/25 and progress that has been made in refreshing the Joint Forward Plan (JFP) for 2024/25. System stakeholders are being engaged earlier in the planning process to enable greater input into the plans. A first DRAFT of the JFP 2024/25 is included at Appendix 1. A portfolio planning away day was held on 13th December 2023 to enable portfolio leads to share their draft system programme plans and the group to identify gaps, areas of duplication or synergy, and interdependencies. System programme directors have been asked to update their draft plans by early January 2024. The Barking and Dagenham Local plan is included in the draft plan and work is progressing to confirm the priorities and delivery plan. National NHS priorities and planning guidance for 2024/25 is not expected to be published before the end of January, however, priorities set out in the 2023/24 planning guidance and recovery plans are expected to remain. New capital planning guidance requires the ICB and partner trusts to publish their capital resource plan by 1 April and ensure that it is consistent with the JFP.
Action / recommendation	The committees are asked to: • note the planning update • review and comment on the first JFP 2024/25 draft document (Appendix 1- Draft JFP 24/25)

Reasons	The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England, and their partner NHS trusts and foundation trusts, to produce and publish a Joint Forward Plan (JFP). The JFP is expected to be a delivery plan for the integrated care strategy of the local Integrated Care Partnership (ICP) and relevant joint local health and wellbeing strategies (JLHWSs), whilst addressing universal NHS commitments.
Previous reporting	▪ Clinical Advisory Group – 6th Dec 2023 ▪ ONEL JOSC – 9th Jan 2024 ▪ Acute Provider Collaborative Execs – 9th Jan 2024 ▪ ICP Committee – 10th Jan 2024 ▪ Primary Care Collaborative sub-committee – 10th Jan 2024 ▪ Community Health Collaborative Sub-Committee 15th Jan 2024
Next steps/ onward reporting	▪ All Place HWBBs and/ or Health & Care Partnership Boards – Jan to Feb 2024 ▪ INEL JOSC – 23RD Jan 2024 ▪ MHLDA Collaborative sub-committee – 31st Jan 2024 ▪ Exec Committee (sign-off) – 7th Mar 2024 ▪ CAG (sign-off) – 13th Mar 2024 ▪ ICB Board (sign-off) – 27th Mar 2024
Conflicts of interest	N/A
Strategic fit	The report aligns with the following system objectives: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The annual refresh of the NEL Joint Forward Plan aims to support the maturity of our system in being able to deliver our four core priorities and cross cutting themes, which in turn are linked to reducing health inequalities.
Impact on finance, performance and quality	The Joint Forward Plan in itself does not detail the finance, performance and quality aspects of the system.
Risks	There is a risk that the late publication of national NHS planning guidance, and requirement to submit the JFP by the end of March, will require further work to be done to ensure that plans are aligned. There is a risk that that the programme resource requirements are insufficient to deliver the ambitions of the plan.

1.0 Purpose

1.1 A paper setting out the system planning process for 2024/25 was presented to the Committees in Common in November 2023. The purpose of this paper is to update the Committees on the planning process and receive feedback on the draft plans.

2.0 Background

2.1 North East London Integrated Care System (ICS) is in the process of refreshing the Joint Forward Plan (JFP) for 2024/25. The aim is to finalise the plan by the 23rd February and following ICB Board approval in March, submit to NHSE.

2.2 Based on feedback and lessons learnt from this year's JFP development, we are now engaging with NEL System stakeholders earlier within the system planning cycle in order to ensure improved awareness of and input to the 2024/25 JFP.

2.3 As a partnership, we continue to work towards developing a cohesive and comprehensive delivery plan for meeting the challenges we face. As part of these annual refreshes going forward we will work with local people, partners and stakeholders to iterate and improve the plan as we develop our partnership, to ensure it stays relevant and useful to partners across the system.

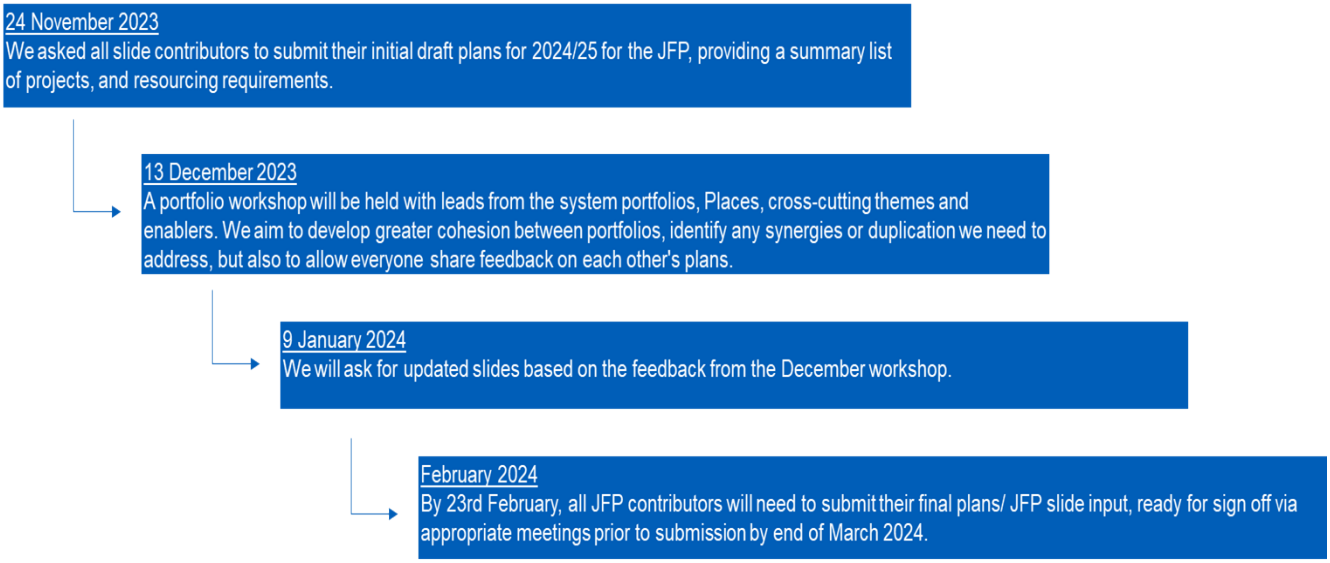
2.4 For the 2024/2025 refreshed document we have maintained much of the core information and headlines that are in the current iteration, updating and amending statistics and information where relevant.

2.5 An unedited first DRAFT of the JFP 2024/25 has been attached as an appendix, to indicate the direction of travel. A further draft will be available by end of January 2024, with a final draft by end of February. An electronic copy can be made available upon request.

2.6 The Committees are asked to provide any feedback on the DRAFT Forward Plan by 23rd January in order for this to be considered in the final draft document.

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

3.1 The timeline for refreshing the JFP is outlined below:



3.2 A portfolio planning away day was held on 13th December 2023 to enable portfolio leads to share their draft system programme plans and the group to identify gaps, areas of duplication or synergy, and interdependencies. System programme directors have been asked to update their draft plans by early January 2024.

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

Main additions:

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

3.4 The Barking and Dagenham Place plan is included on as slide 47 of the pack. The aim is to focus on a smaller number of priority areas that are shared across the partnership and support the achievement of our Joint Local Health and Wellbeing Strategy outcomes. Recognising that we do not have the resources to do everything, we will be focusing on areas that we believe we could deliver a positive impact on resident experience and outcomes through partnership working and taking a preventative approach to health and care.

4.0 Other planning activities

4.1 NHS priorities and planning guidance for 2024/25 has been delayed and is not expected to be published before the end of January. A letter received from NHSE on 23rd December 2023 has confirmed that the priorities and objectives set out in the 2023/24 planning guidance and published recovery plans on urgent and emergency care, primary care access and elective and cancer care will not fundamentally change.

4.2 A key requirements will be for systems to maintain the increase in core urgent and emergency care capacity established in 2023/24, complete the agreed investment plans to increase diagnostic and elective activity and reduce waiting times for patients, and maximise the gain from the investment in primary care in improving access for patients, including the new pharmacy first service. The final position and performance expectations will be confirmed in Planning Guidance.

4.3 National guidance released in December 2023 states that ICBs and their partner trusts must prepare a plan setting out their planned capital resource use, before the start of each financial year (by 1 April), publish the plan and share with their integrated care partnership, health and wellbeing boards and NHS England. The content of the JFP should be consistent with the capital plan.

5.0 Risks and mitigations

5.1 There is a risk that the late publication of national NHS planning guidance, and requirement to submit the JFP by the end of March, will require further work to be done to ensure that plans are aligned.

5.2 There is a risk that that the programme resource requirements are insufficient to deliver the ambitions of the plan.

6.0 Recommendations

6.1 The committees are asked to:

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

7.0 Attachments

- Appendix1: Joint Forward Plan 24/25 refresh; Health and Wellbeing Board

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APPENDIX 1

NHS
North East London

Joint Forward Plan 24/25 Refresh:

Health & Well Being Board

16th January 2024

DRAFT

Introduction and considerations for the NEL HWBBs:

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

Considerations for the HWBB membership:

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

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

2) note the amended content proposed

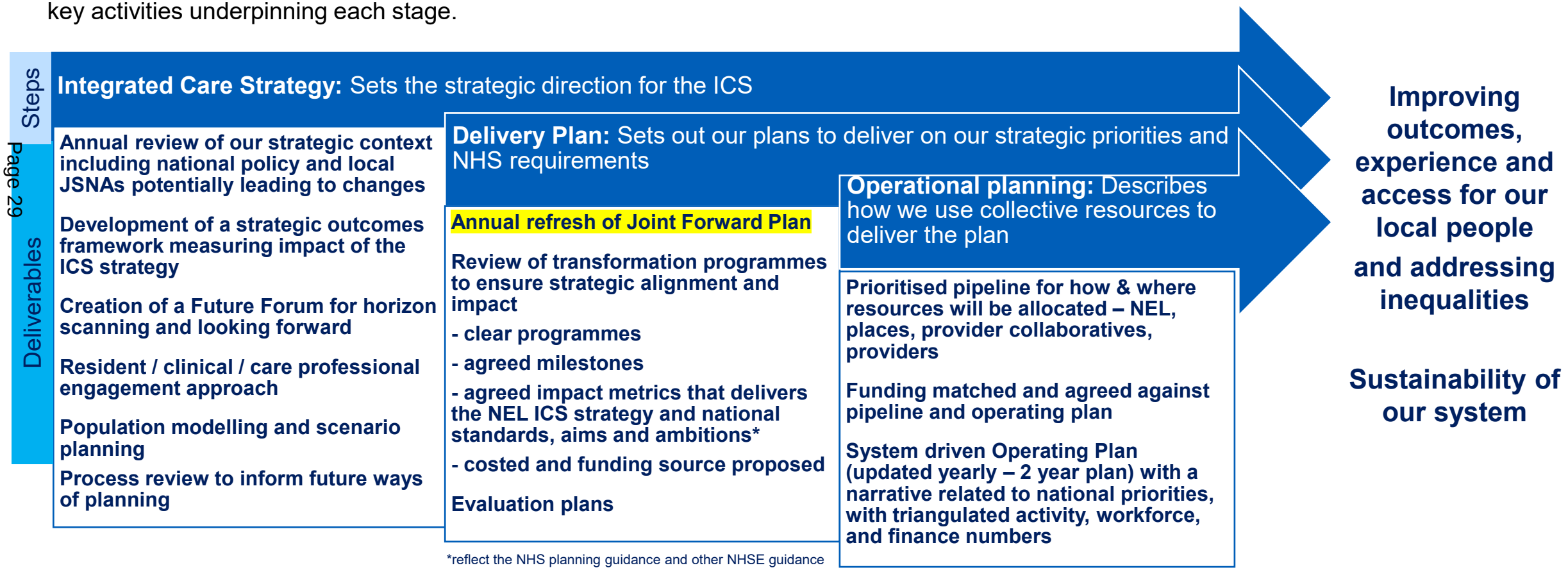
3) review and comment on the first JFP 24/25 draft document (Appendix 1- Draft JFP 24/25)

Overview of system planning approach

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

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

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



*reflect the NHS planning guidance and other NHSE guidance

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

- Based on feedback and lessons learnt from this year's JFP development, we are now engaging with NEL System stakeholders earlier within the system planning cycle in order to ensure improved awareness and input to the 24/25 JFP.
- There will be annual refreshes of the JFP going forward in order to ensure that the document remains current. This JFP refresh continues to describe the challenges that we face as a system in meeting the health and care needs of our local people, but also the assets we hold within our partnership.

High-level timeline

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

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

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

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

Main changes from the previous JFP

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

Main additions:

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

23rd December 2023 – NHSE Guidance Released:
Guidance includes request that ICBs develop a 'capital resource use plan' to which the content of the JFP should be consistent with.

NHS
North East London

Appendix 1:

24/25 Joint forward plan - draft document

(Note: Not for wider circulation)

North East London Health & Care Partnership

NHS North East London

North East London (NEL) Joint Forward Plan - Refresh

December 2023

DRAFT

ALL SLIDES WITHIN THIS PACK ARE DRAFT VERSIONS

1. Introduction

DRAFT

Introduction

- This Joint Forward Plan is north east London's second five-year plan since the establishment of NHS NEL. In this plan, we build upon the first, refreshing and updating the challenges that we face as a system in meeting the health and care needs of our local people, but also the assets we hold within our partnership.
- We know that the current model of health and care provision in north east London needs to adapt and improve to meet the needs of our growing and changing population and in this plan we describe the substantial portfolio of transformation programmes that are seeking to do just that. We have now also included new slides our cross cutting themes and each of our seven Place based partnerships.
- The plan sets out the range of actions we are taking as a system to address the urgent pressures currently facing our services, the work we are undertaking collaboratively to improve the health and care of our population and reduce inequalities, and how we are developing key enablers such as our estate and digital infrastructure as well as financial sustainability.
- Our Joint Forward Plan will be refreshed yearly to reflect that, as a partnership, we have continual work to do to develop a cohesive and complete action plan for meeting all the challenges we face together. We will work with local people, partners and stakeholders to update and improve the plan yearly as we develop our partnership, to ensure it stays relevant and useful to partners across the system.

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

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

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

DRAFT

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

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

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

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

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

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

Critically we are committed to a relentless focus on equity as a system, embedding it in all that we do.

Both the strategy and this Joint Forward Plan build upon the principles that we have agreed as London ICBs with the Mayor of London

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

Improve quality and outcomes	Deepen collaboration	Create value	Secure greater equity

6 Crosscutting Themes underpinning our new ICS approach

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

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

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

Securing the foundations of our system

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

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

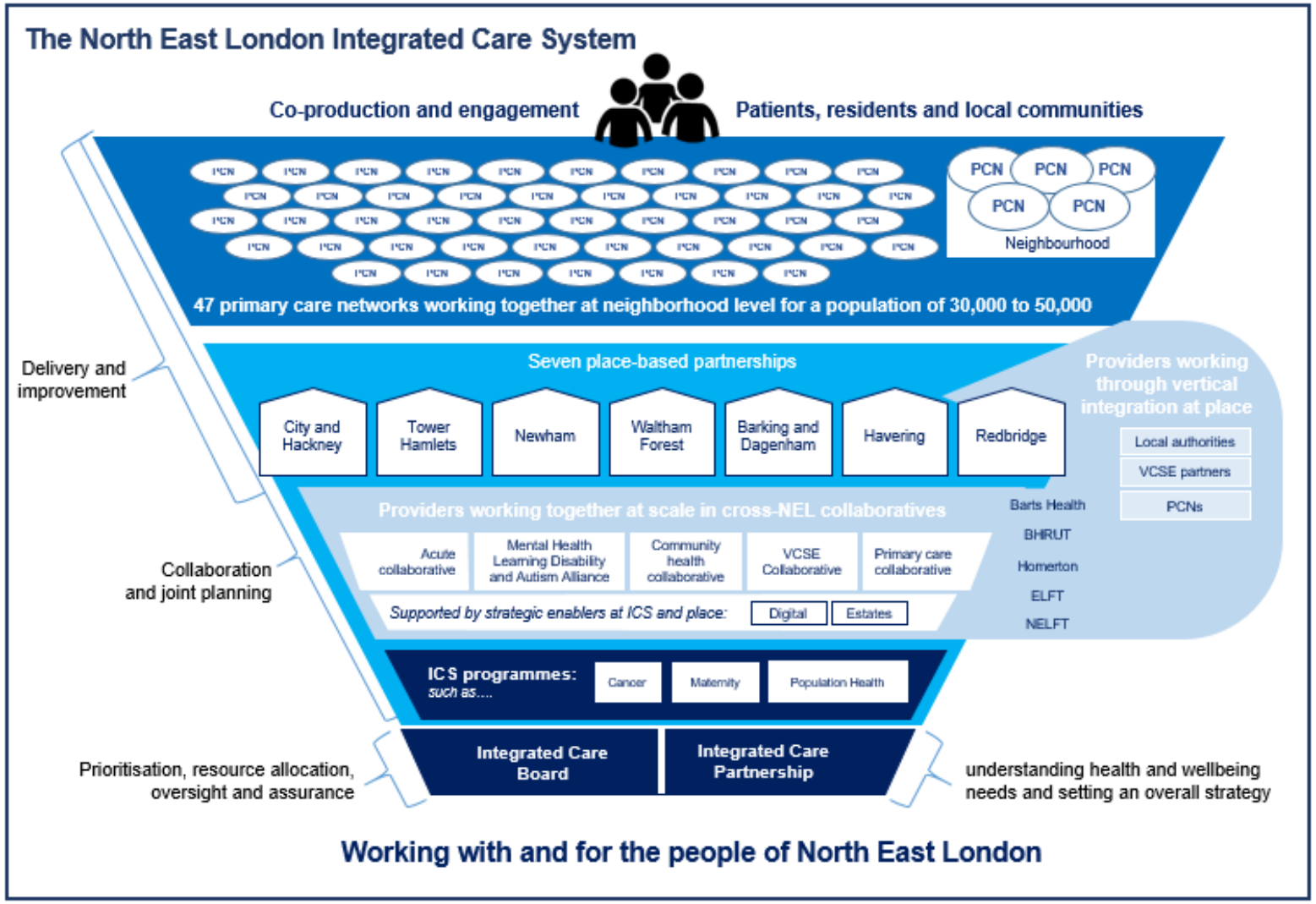
We are a broad partnership, brought together by a single purpose: **to improve health and wellbeing outcomes for the people of north east London**.

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

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

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

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



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2. Our unique population

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

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

Rich diversity

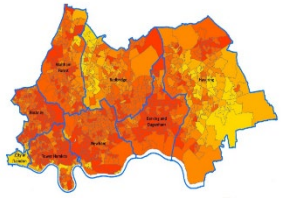
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from ethnic minority backgrounds.

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

Young, densely populated and growing rapidly

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

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



Poverty, deprivation and the wider determinants of health

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

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

Stark health inequalities

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

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

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Engaging our residents across NEL about their health, care and wellbeing

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.

What does good care look like?

Over summer 2023 we engaged with around 2000 people, including an online survey, face to face community events and targeted focus groups including with 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.**

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

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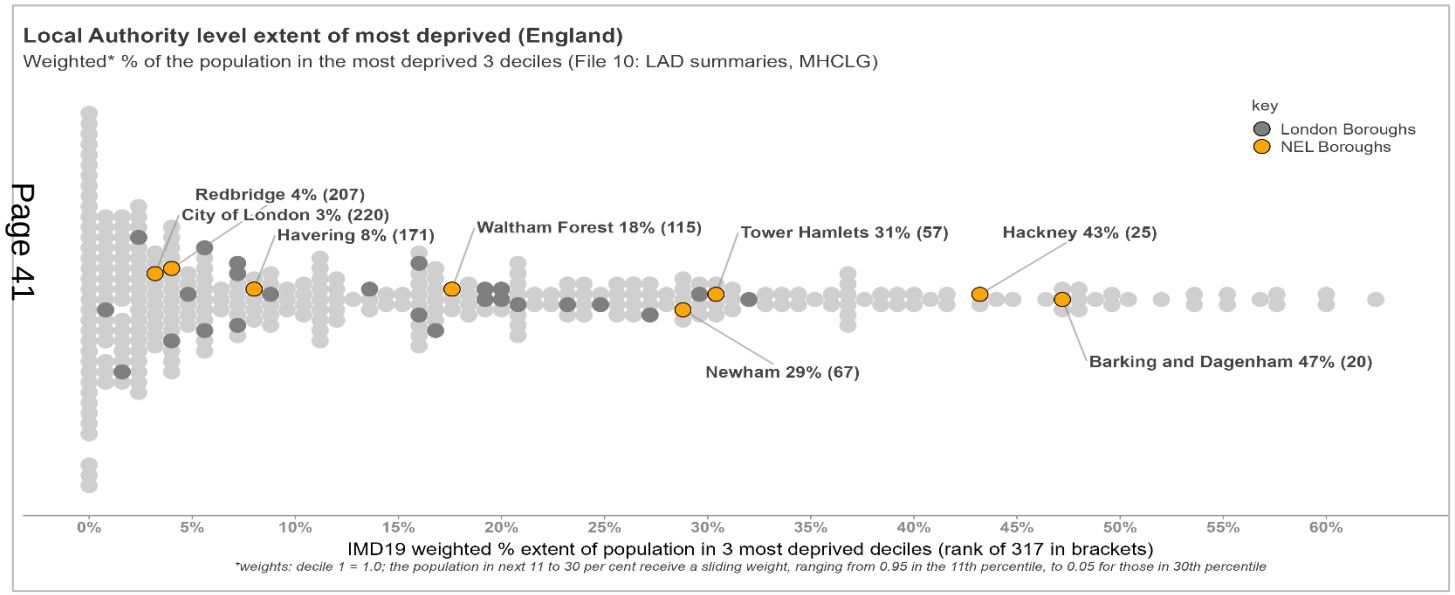
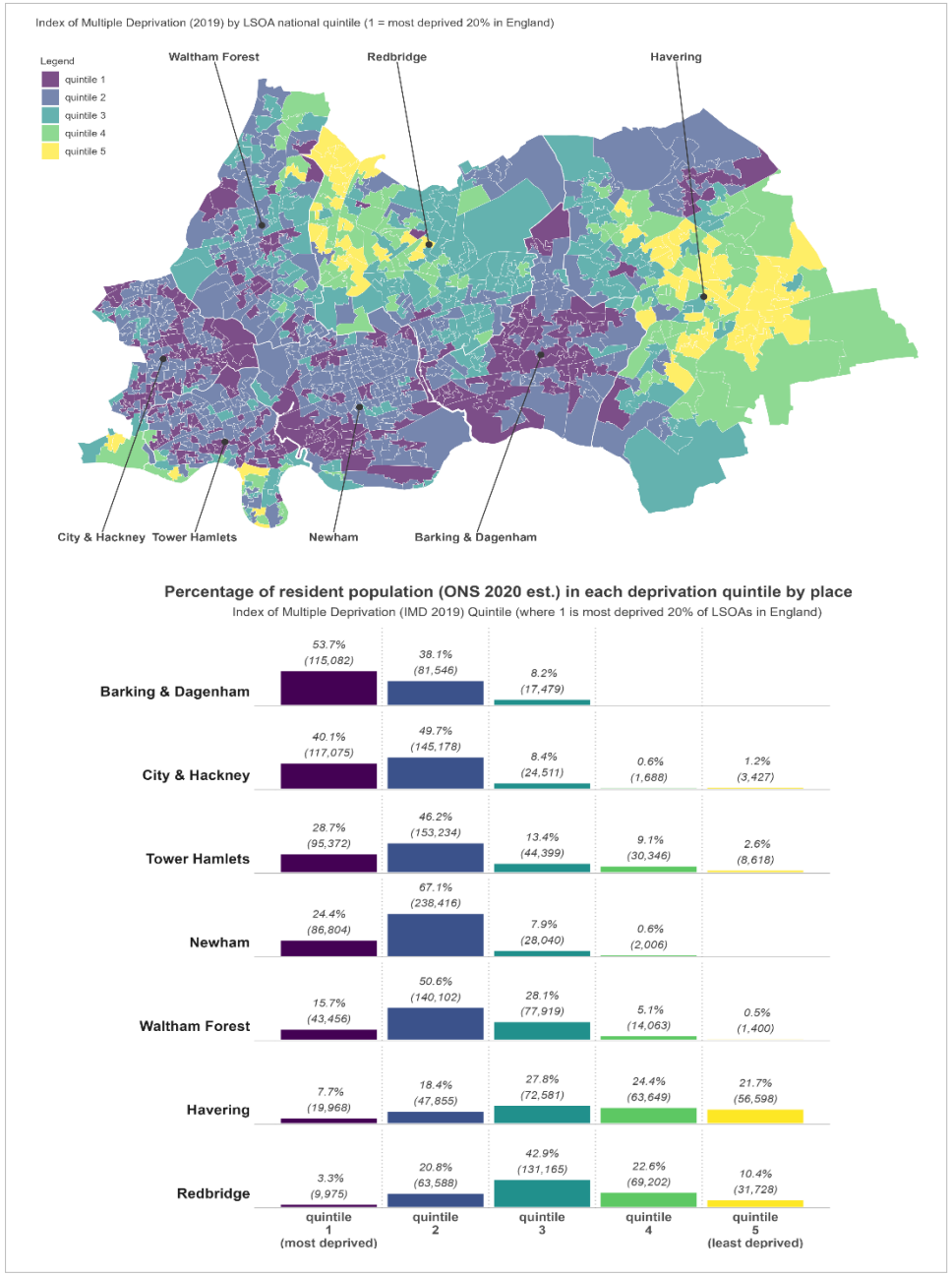
Key factors affecting the health of our population and driving inequalities - poverty, deprivation and ethnicity

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

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





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

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

Child Obesity

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

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

Mental Health

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

Tobacco

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

Premature CVD mortality

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

Vulnerable housing

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

Homelessness

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

Childhood Poverty

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

Childhood Vaccinations

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

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

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

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

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

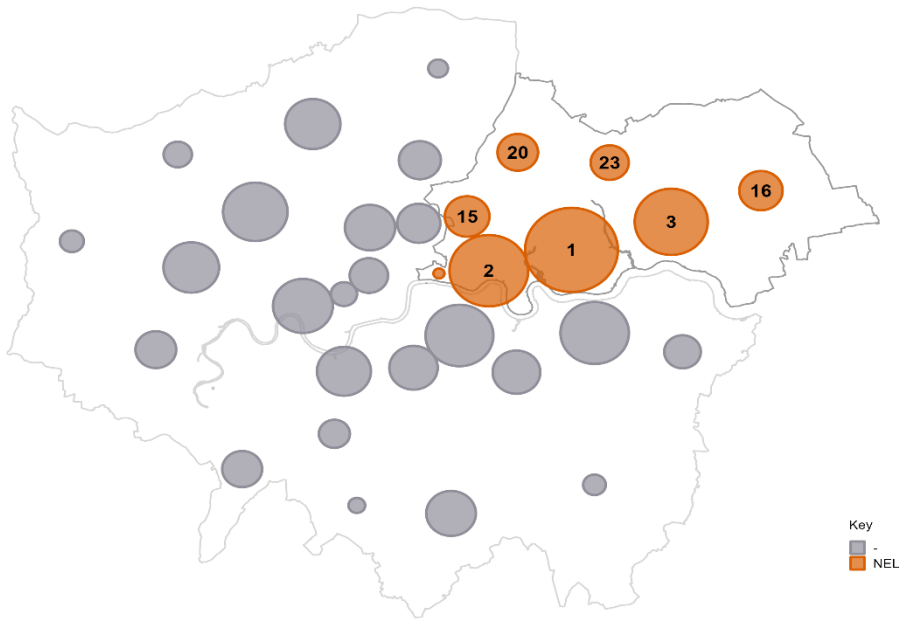
The population of north east London (currently just over 2 million) is projected to increase by almost 15% (or 300k people) between 2023 and 2040. This is equivalent to adding a whole new borough to the ICS, and is by far the largest population increase in London.

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

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

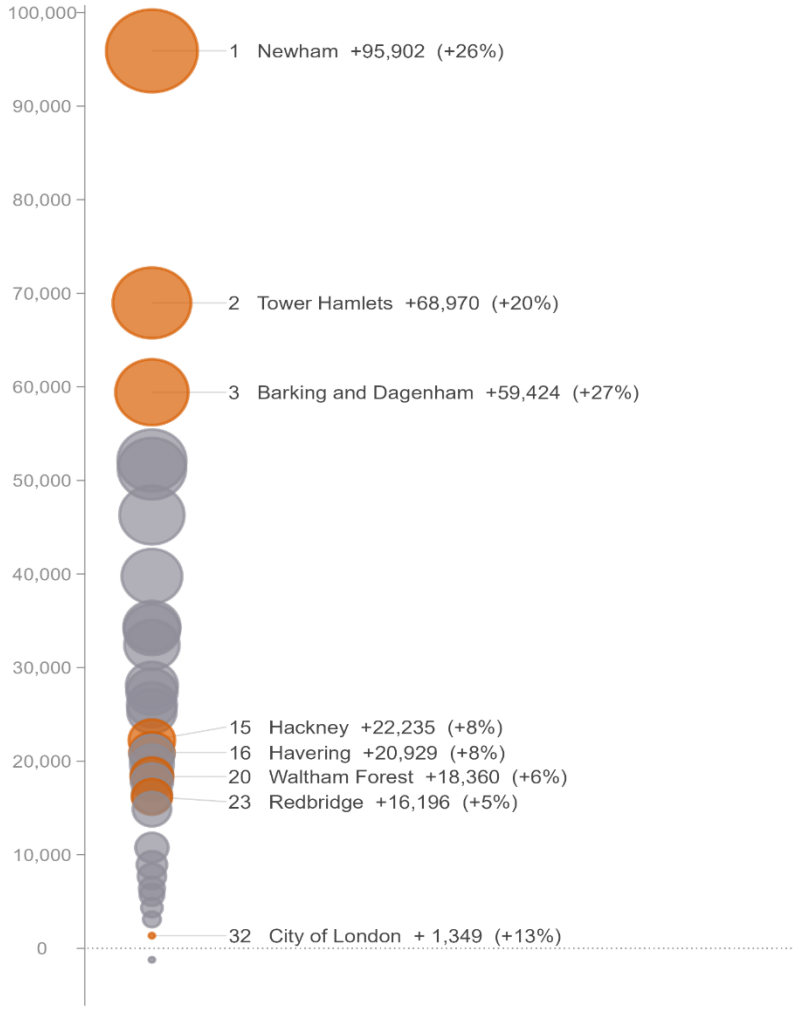
In addition, the age profile of our population is set to change in the coming years. Our population now is relatively young, however, some of our boroughs will see high increases in the number of older people as well as increasing complexity in overall health and care needs.

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



GLA Identified Capacity Scenario, published September 2021, 2020 based

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



GLA Identified Capacity Scenario, published September 2021, 2020 based

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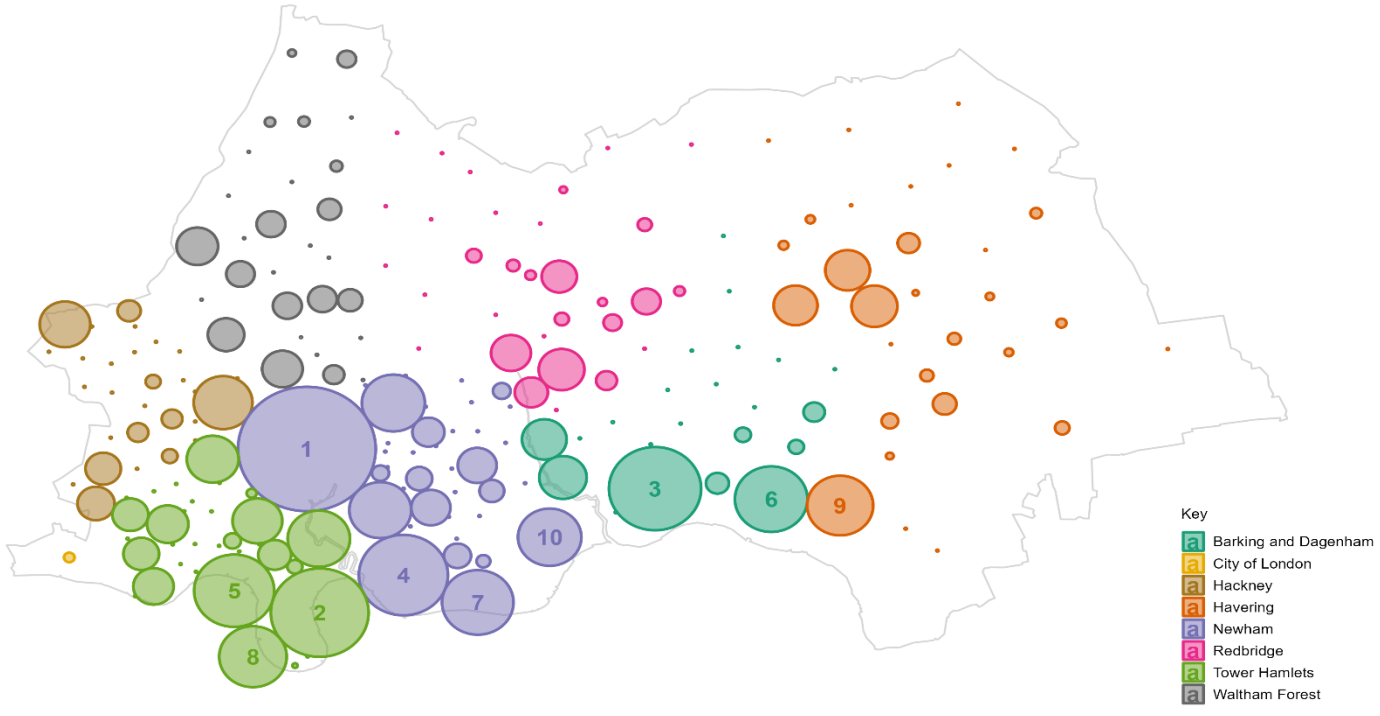
We need to act urgently to improve population health and address the impact of population growth

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

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

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

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



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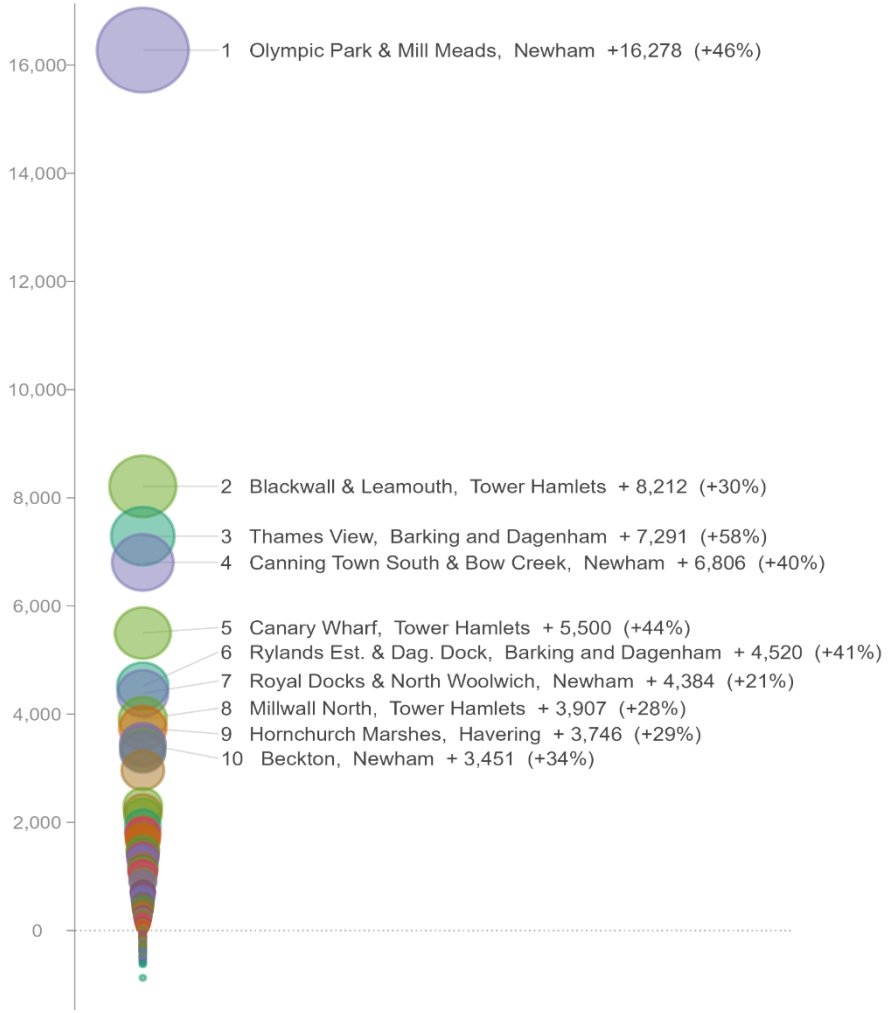
NEL neighbourhood (MSOA) all age population increase 2023-2028

Labelled circles = top 10 NEL neighbourhoods by population increase



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3. Our assets

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We have significant assets to draw on

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

Our assets

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

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

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

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

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

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Our health and care workforce is our greatest asset

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

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

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

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

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

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

Our workforce includes:

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

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

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

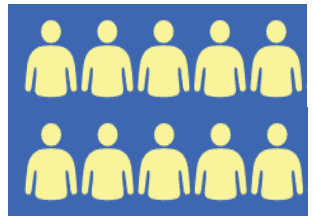
In NEL we are supporting the development of a VCSE Collaborative to create the enabling infrastructure and support sustainability of our rich and diverse VCSE in NEL, also ensuring that the contribution of the VCSE is valued equally.

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

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

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

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



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

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

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4. Our challenges and opportunities

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The key challenges facing our health and care services

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

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

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

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

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

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

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

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Urgent and emergency Care including Transformation - is a system priority following the publication of the National UEC Recovery Plan

Key challenges	*Detail*
Nationally demand for urgent and emergency care 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. • 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, 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: • 1) population growth, • 2) an ageing population, and; • 3) 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. In NEL our bed occupancy has seen an increasing trend in the last 8 weeks. When our hospitals are full it is harder to find free beds for patients that need to be admitted. • 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 an average of 10.79% of our G&A hospital beds are occupied 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. 36.8% of A&E mental health attendances were waiting over 12 hours. This is an uptrend in the last QR across NEL

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We have a large backlog of people waiting for planned care

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

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

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

- North-east London currently has fewer GP appointments per 100,000 weighted population than other ICSs in England. The national median is around 8% greater than in NEL, suggesting part of the cause of pressure on other parts of the system, including greater than expected non-elective admissions at the acute providers, may be due to insufficient primary care capacity.
- 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 ranges from 93.56 per 1000 (weighted registered) patients in Tower Hamlets, to 68.01 per 1000 (weighted registered) patients in Havering. The NEL average is 77.78 per 1000 (weighted registered) patients.**
- 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 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, based on MDTs, social prescribing and use of community pharmacy consultation services, which will strengthen both our continuity of care of long term conditions and our ability to work preventatively.

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 improves 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, mental health survives, pharmacy, care homes links to hospitals and voluntary/community organisations.

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

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Develop and build upon our community care resources

- Community care in north east London is currently fragmented, with four core provider trusts and over 65 other providers offering an array of community services. More work is required to understand the impact this has on patient outcomes and variability across NEL's places, but we know that for pulmonary rehab, for example, there is variation in service inclusion criteria and the staffing models used, and that waiting times vary between 35 and 172 days, with completion rates between 36% and 72% across our places and services.

- There are significant opportunities and synergies to improve community pathways given the co dependencies with neighborhood teams, long term conditions, planned care , primary care and UEC. Community services are key to optimizing admission avoidance and discharge but a resource shift is required to enhance preventative and community pathways

- More children and young people are on community waiting lists in NEL than any other ICS (NEL is about average, across England, for the number of people on adult community waiting lists). Particular challenges are SALT, community pediatrics and neurodiversity pathways

- Our adult waiting lists are very pressured , particularly regarding MSK pathways, SALT, podiatry and dietetics

- Identifying and understanding the areas of greatest population and community need will provide a basis for community health care leads to support a joint planning approach. Allowing for agreement on priority areas under the context of service pressures. Approaching community health care in a targeted way and focusing on those areas of greatest need will also support reducing variance in services across the NEL system

- There is a need for a clear and current overview of community health services across the system and places. Linked to also being able to monitor the outcomes for residents of those services and the resources utilized, this will ensure that the NEL system is able to make the most efficient use of those community health services for the population.

- Improvement networks give us an opportunity to bring together best practice, jointly work on solutions that are led by clinicians and subject matter experts, in partnership with our users and carers. This approach will ensure equitable and consistent pathways, that are delivered locally and tailored to meet local population needs.

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

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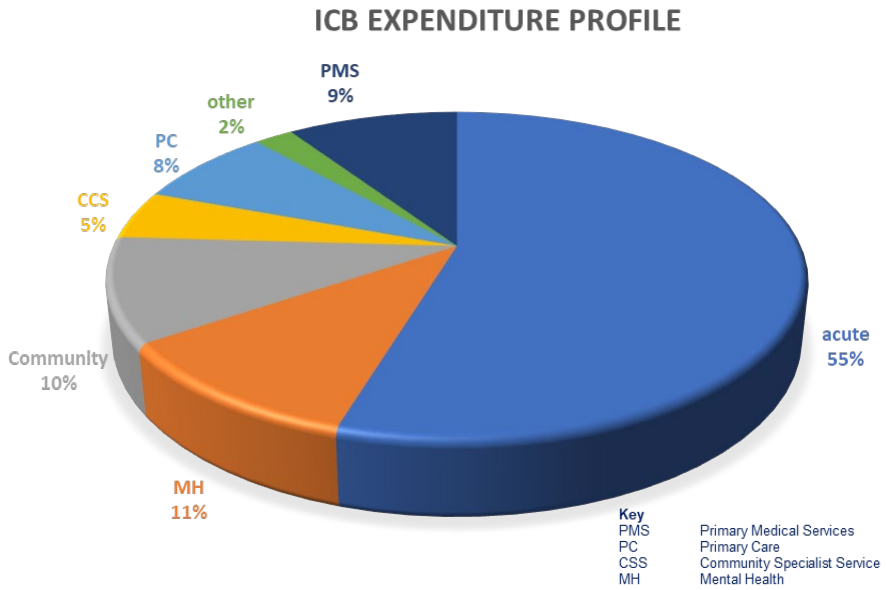
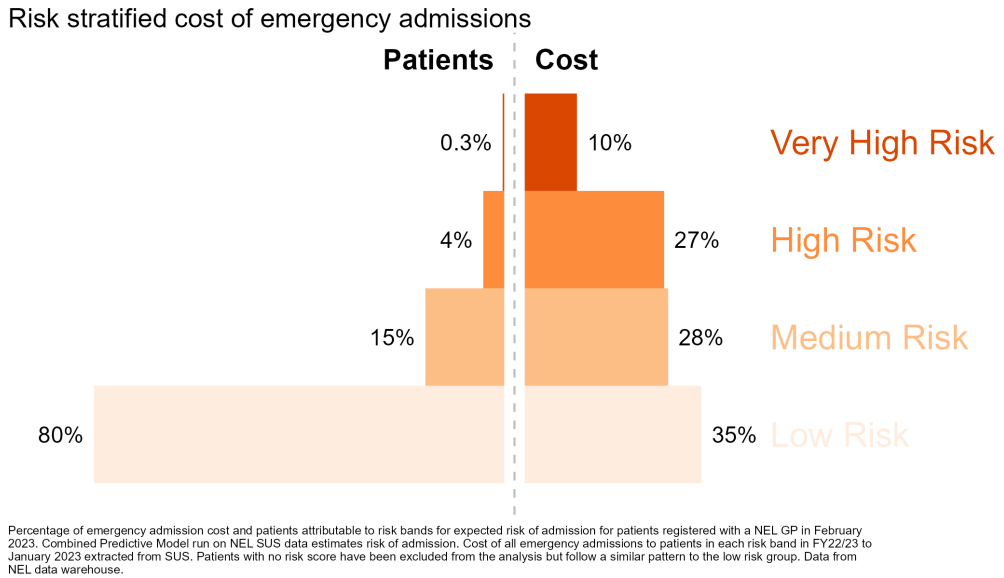
We need to move away from the current blend of care provision which is unaffordable

- The system has a significant underlying financial deficit, held within the Trusts and the ICB. Going into 2023/24 this is estimated to be in excess of £100m. This is due to a number of issues, including unfunded cost pressures.
- The system has therefore developed a financial recovery plan, which if delivered would result in a £31m deficit in 23/24.
- Current plans to improve the financial position, such as productivity/cost improvement programmes within the Trusts, are expected to close some of this financial gap and we know there are opportunities for reducing unnecessary costs, such as agency spend. The system is also looking at a range of further measures designed to improve the underlying run rate.
- In addition to a financial gap for the system overall, there are discrepancies between how much is spent (taking into account a needs-weighted population) across our places, in particular with regard to the proportion spent on out of hospital care.
- The system receives a very limited capital budget in 23/24 of £95m, significantly less than other London ICSs (which receive between £130m-£233m) and comparable to systems with populations half the size of NEL*. This puts significant pressure on the system and its ability to transform services, as well as maintain quality estate. In 24/25 the estimated budget is £86m.
- There is huge variation in the public health grant received by each of NEL's local authorities from central government. The variation is at odds with the government's intended formula (which is based on SMR<75) and is the result of grants largely being based on historical public health spend. This impacts on our ability to invest upstream in preventative services.
- As a system the majority of our spend is on more acute care and we know that this is driven by particular populations (0.3% of the population account for 10% of costs associated with emergency admissions; just under 20% account for 65%).





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

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

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We are making progress – Our successes

Examples of transformation we have driven within existing resources

Cardiovascular Disease:

NEL ICS is the top ranking 1st in England in key Cardiovascular disease outcomes including management of hypertension, atrial fibrillation, chronic kidney disease, heart disease and stroke, and people at high CVD risk.

Long Term Conditions:

The Non-Invasive Ventilation (NIV) Service, which went live in April 22, has been put in place for the management of chronic hypercapnic respiratory failure (CHRF). Previously the service was only available through Tertiary institutions however will now be delivered locally by BHRUT to patients at home.

Children's LTCs:

City and Hackney practices have led the development of Long term conditions (LTC) integrated management with 80% of eligible children receiving an annual review with personalised care plan, 65% of children with diabetes, sickle cell and epilepsy receiving an annual care contact from their practice.

Elective Services:

We have an established planned care recovery and transformation programme. An integrated system programme initially set up in October 2021 to recover the elective backlog and improve equity of access for our population, led by the Acute Provider Collaborative.

ELFT Community Health Services:

Pharmacy input into district nursing teams (HSJ Award category finalist) improved outcomes for both medicines management and medicines optimisation. Delivered via system innovation and new ways of working

First Contact Physiotherapy:

An integrated PCN wide physiotherapy clinic that required the set-up of a cross organisational booking system. Resulting in beneficial patient experience.

Young Peoples Outpatient Services:

Tower Hamlets has established a young people's GP clinic called 'Health Spot' aligned with youth provision rights in order to provide a trusted approachable environment where young people are able to see a doctor, specialist nurse or mental health worker. Supporting them with integrated holistic healthcare, health literacy and empowerment.

Transforming Outpatient Services:

Our GPs can now receive advice directly from a number of specialist consultants, reducing hospital attendance and giving speedy care. In 2022/23 we achieved against the 16% national ask for advice and guidance requests across 2022/23, and for approximately 29% of all outpatient appointments in January.

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5. How we are transforming the way we work

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

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

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

Urgent and emergency care

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

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

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

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

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

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

April 2026:
-

April 2027:
-

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

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Community Health Services

Portfolio vision, mission and key drivers:

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

Key stakeholders:

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

Key programmes of work that will deliver the vision and mission

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

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

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

Co dependencies on other programmes

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

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

Engagement with the public:

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

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Primary Care

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

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

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

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

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

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

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

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

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

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

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

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

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Planned Care

Portfolio vision, mission and key drivers:

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

Key stakeholders:

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

Key programmes of work that will deliver the vision and mission

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

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

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

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

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

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

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

Engagement with the public:

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

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Cancer

Portfolio vision, mission and key drivers:

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

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

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

- **Drivers**
- Our work enables the ICB to achieve its objectives, as set out in the strategy, across the ICB's six cross-cutting themes:
- Tackling Health Inequalities
- Greater focus on Prevention
- Holistic and Personalised Care
- Co-production with local people
- Creating a High Trust Environment that supports integration and collaboration
- Operating as a Learning System driven by research and innovation

Key stakeholders:

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

Key programmes of work that will deliver the vision and mission

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

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

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

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

2025/26:

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

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

Engagement with the public:

Patient Reference groups
Campaign workshops

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Maternity

Portfolio vision, mission and key drivers:

- Three year delivery plan for maternity and neonatal services: 2023-2026. . This has consolidated the improvement actions committed to in Better Births, the NHS Long Term Plan, the Neonatal Critical Care Review, and reports of the independent investigation at Shrewsbury and Telford Hospital NHS Trust and the independent investigation into maternity and neonatal services in East Kent. The expectations on Local Maternity and Neonatal Systems are that they focus on the following areas;
- ➢ Listening to, and working with, women and families with compassion
- ➢ Growing, retaining, and supporting our workforce
- ➢ Developing a Culture of safety, learning and support
- ➢ Standards and structures that underpin safer, more personalised and more equitable care

Key stakeholders:

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

Key programmes of work that will deliver the vision and mission

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

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

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

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

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

Engagement with the public:

MNVPs, Third Sector organisations and communities identified in the E&E LMNS report.

Babies, children and young people

Portfolio vision, mission and key drivers:

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

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

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

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

Key stakeholders:

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

Key programmes of work that will deliver the vision and mission

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

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

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

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

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

Engagement with the public:

Via Providers.
SEND Parent's Forum
National Voices

Long Term Conditions

Portfolio vision, mission and key drivers:

Our vision - To support everyone living with a long-term condition in North East London to live a longer, healthier life and to work to prevent conditions occurring for other members of our community, and support communities to prevent LTC onset or progression

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

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

Key drivers –

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

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

- Across NEL, one in four (over 600 thousand people) have at least one long-term condition, with significant variation between our places (in Havering, the figure is 33%, vs 23% in Newham and Tower Hamlets)
- NEL is the highest performing ICB in England for many outcomes related to CVD, stroke, and renal, but local social demographics put the system at risk of continued growth in demand
- Nationally, long-term conditions account for half of GP appointments, 64 percent of all outpatient appointments, and over 70 percent of all inpatient bed days.
- The most deprived areas, people acquired three or more conditions (complex multimorbidity) when they were 7 years younger, compared with the least deprived.

Key stakeholders:

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

Key programmes of work that will deliver the vision and mission

Primary LTC prevention & Early identification

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

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

Secondary prevention and avoiding complication

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

Co-ordinated care and equability of service

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

Enabling people to live well with a LTC and tertiary prevention

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

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

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

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

Organisation Delivery Networks (renal and CVD/cardiology)

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

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

Work toward national targets including:

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

Engagement with the public:

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

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

Mental Health

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

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

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

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

Key programmes of work that will deliver the vision and mission

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

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

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

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

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

Employment and workforce

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

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

Key programmes of work that will deliver the vision and mission
- **System Workforce Productivity:** Continuing to address NEL’s difficult financial position through urgent investigation of workforce productivity drivers and implementation of productivity improvement initiatives.
- **System Strategic Workforce Planning:** Development of a strategic workforce planning function with the capacity, capability and digital enablers to provide the enable evidence-based decisions to ensure the long-term sustainability of the NEL Health and Social Care workforce. With the ultimate aim of developing of a system-wide health and social care workforce database and an integrated workforce planning system.
- **System Anti Racist Programme:** Embedding inclusive, anti-racist and empowering cultures across the system.
- **System wide scaling up and corporate services:** Identification of corporate services with scope for rationalisation. Streamlining operations, improving efficiency, standardising approach and reducing costs.
- **NEL Health Hub Project Programme:** Connecting local health and social care employers with colleges for employment opportunities. . Healthcare part is in partnership with Newham College and London Ambulance service and funded by GLA until March 2024. Social Care part is led by Care Provider Voice, aiming for 200 job outcomes, and funded until March 2025.
- These programmes are subject to approval by the People Board, Exec Committee, CPOS, Place, and collaboratives, aligning with the goal of enhancing socio-economic status in NEL through workforce development.

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

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

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

Specialist Commissioning

Portfolio vision, mission and key drivers:

Our vision:

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

Our mission and drivers:

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

Key programmes of work that will deliver the vision and mission

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

The key programmes of work are to:

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

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

HIV

- People living with HIV will have improved follow up care with investment in a community led peer programme with an aim to reduce by 70% the number of eligible patients that are lost to care/failed by care. This follow up care will include regular testing, counselling, mentoring, group support, assurance and information and advice.

Renal

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

Sickle Cell

- Local people with sickle cell will receive appropriate analgesia and other pain management measures (ideally within 30 minutes) when attending any acute A&E in NEL
- Residents will have timely access to multi-disciplinary team to support delivery of trauma-informed care based on the principles of safety, trust, choice, collaboration, empowerment and cultural competence.

Hepatitis and HIV

- To achieve micro elimination of HCV across NEL (2025).
- Improved access to diagnostics and increase local prevention programmes by aligning with the British Liver Trust optimal pathway. This will support the reduction in the growth rate of liver disease (currently 20%).

Neurosciences

- 10% of eligible stroke admissions will have consistent 24/7 access to mechanical thrombectomy to reduce the impact of stroke
- Improve detection of atrial fibrillation and ensure appropriate stroke risk reduction through anticoagulation - by 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation.

Cardiology

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

Key stakeholders:

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

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

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

Engagement with the public:

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

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Digital

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

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

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

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

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

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

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

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

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

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Finance

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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Physical infrastructure

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

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

- Across NEL ICS organisations, there are 332 estates projects in our pipeline over the next 5 /10 years, with a total value of c. £2.9 billion
- These include the redevelopment of Whipps Cross hospital and a new centre on the site of St George's, Hornchurch
- Formal opening of new St George Health and Wellbeing Hub – **Spring 2024**

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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Barking & Dagenham

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

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

Interdependent ICB programmes

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

Interdependent Collaborative programmes

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

Key programmes of work that will deliver the vision and mission

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

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

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

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

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

Havering

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

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

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

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

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

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

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

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

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

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

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

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

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

Redbridge

Place vision, mission and key drivers:

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

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

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

Interdependent ICB portfolios

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

Interdependent Provider Collaboratives

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

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

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

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

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

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

Health Inequalities: Various schemes addressing Core 20+5

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

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

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

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

Key stakeholders:

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

Engagement with the public:

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

Tower Hamlets

Portfolio vision, mission and key drivers:

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

Interdependent ICB programmes

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

Interdependent Collaborative programmes

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

Key programmes of work that will deliver the vision and mission

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

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

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

Key stakeholders:

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

Tower Hamlets residents and service users

Engagement with the public:

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

Newham

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

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

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

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

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

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

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

Waltham Forest

Portfolio vision, mission and key drivers:

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

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

Key stakeholders:

Interdependent ICB programmes

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

Interdependent Collaborative programmes

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

Key programmes of work that will deliver the vision and mission

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

Engagement with the public:

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

City & Hackney

Portfolio vision, mission and key drivers:

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

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

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

Interdependent ICB programmes

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

Interdependent Collaborative programmes

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

Key programmes of work that will deliver the vision and mission

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

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

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

Start Well

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

Live Well and Age Well

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

Mental Health

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

Key stakeholders:

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

Engagement with the public:

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

Health Inequalities

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

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

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

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

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

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

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Prevention

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 if we also work 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 stakeholders:
Public health teams
Local authority departments
Voluntary and community sector
Primary care
NHS trusts

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.

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.

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.

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

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Personalised Care

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. 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 stakeholders:
Primary care
Place-based directors
Local authority
Public health teams
VCSFE
NHSE and TPHC
Acute teams e.g. social prescribing & discharge

Key programmes of work that will deliver the vision and mission
- Ensuring all 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 to provide a directory of service platform in alignment with Fuller actions relating to 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.

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 CPPO SMG

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.

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

Learning System

Portfolio vision, mission and key drivers:

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

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

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

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

Key programmes of work that will deliver the vision and mission

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

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

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

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

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

Engagement with the public:

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

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Co-Production

PLACE

HOLDER

SLIDE

<SLIDE IN DEVELOPMENT>

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High Trust Environment

PLACE

HOLDER

SLIDE

<SLIDE IN DEVELOPMENT>

6. Implications and next steps

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Lessons Learnt

Post the submission of the first NEL Joint Forward Plan 23/24 an ‘after action review’ was undertaken in order to reflect on the work undertaken by those stakeholders involved in developing the first Joint Forward Plan. The review included aspects such as recognising what went well and what lessons can be learnt. These outputs were considered when developing the JFP 24/25 refreshed document and will continue to be built upon going forward as the JFP will be refreshed annually.

What went well?	**What can we learn for next time?**
▪ Capturing what key stakeholders are doing in one place ▪ Engagement and developing the place contributions at place ▪ Good support from PMO team ▪ Worked well with local authorities ▪ Involvement from wider range of people across the system ▪ Summary slides are effective in the plan ▪ Collaborative working	• Ensuring that the early draft documents are shared with leads • Ensuring the right people are involved in writing narrative • Too many people involved in drafting JFP, need to narrow this down to only key people that should be involved • Ensuring clinicians are involved from primary care perspective • Need clearer delivery milestones • Clearer guidelines, more notice, understand purpose, value and benefits • Better planning and give enough notice to leads • More connected across finance/strategy/programme in developing the plan • Be clear on how this links with wider programmes/ collaboratives/ Places • Co-ordination of plans at NEL and local level • Need clearer understanding of governance and decision making, accountabilities around programme areas • Ability of contributors to raise queries and seek clarification as required

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How will we know we have succeeded - NEL Outcomes Framework

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

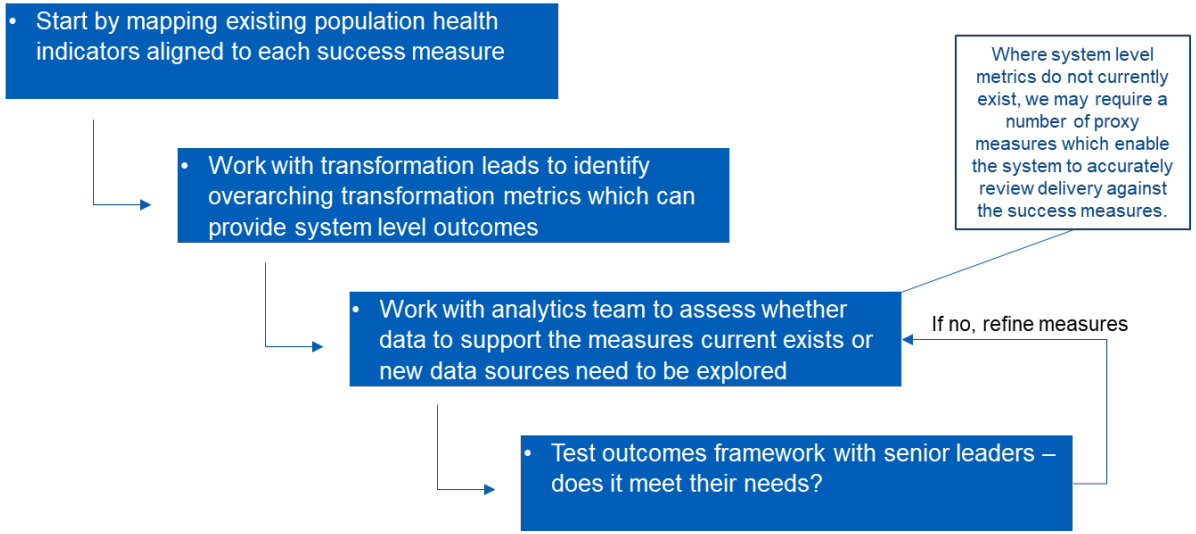
What do we mean by an outcomes framework?

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

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

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

The NEL approach



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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.

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We will continue to evolve as a system

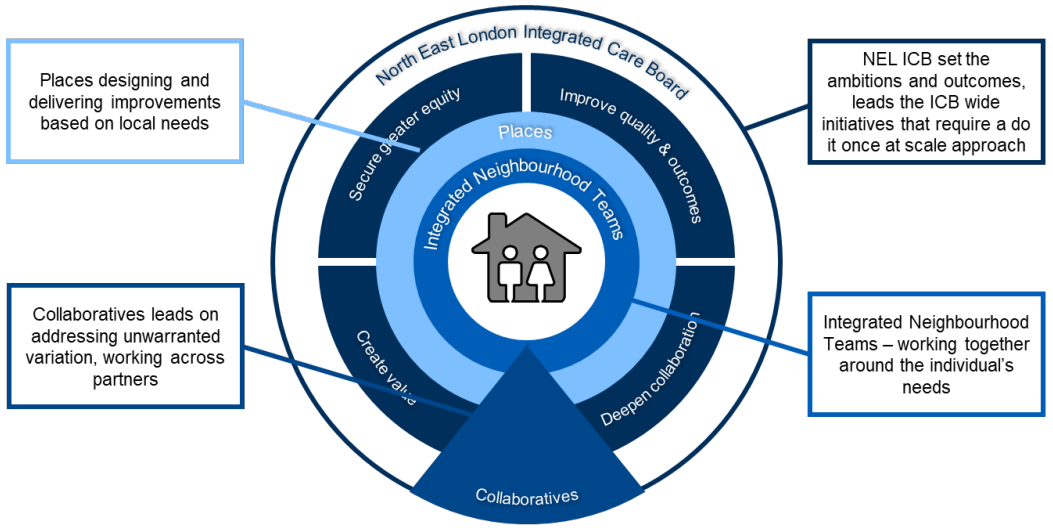
Our system has been changing rapidly over recent years, including the inception of provider collaboratives, the launch of seven place based partnerships, the merger of seven CCGs followed by the creation of the statutory integrated care board and integrated care partnership in July 2022.

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

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

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

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



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

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

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

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North East London
Integrated Care Board

Committees in Common of ICB Sub-Committee and Health and Wellbeing Board

16 January 2024

Title of report	ICB Finance Overview - Month 7 2023/24
Author	Julia Summers, Deputy Director Financial Reporting and Assurance
Presented/Sponsored by	Sunil Thakker, Director of Finance
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Wards affected	All
Key Decision	No
Executive summary	• The attached presentation (Appendix 1) provides a summary of the financial performance of the ICB and ICS, showing a year-to-date October position of an adverse variance to plan of £16.5m for the ICB as part of a £87.2m adverse variance for the ICS. • The report updates on the main drivers of spend and reports on the level of efficiencies required to hit the control total • The ICS has developed a formal recovery plan (FRP) to bring the current run rate expenditure closer to plan. At month 7, factoring into account the impact of industrial action, the ICS is £8.3m adverse to its FRP trajectory. • The ICS submitted an updated forecast position to NHSE after month 7 closedown. This is a movement from the breakeven position to a deficit position. • Barking and Dagenham specific information is presented on BCF, including ageing well and discharge funding. Other place information such as demand and capacity funds, health inequalities and discharge to assess spend will continue to be developed and reported on.
Action / recommendation	The Board/Committee is asked to note the contents of the presentation at Appendix 1.
Reasons	The report provides an update of the financial position against the 2023/24 budget.

Previous reporting	ICB and ICS reporting to ICB Finance, Performance and Investment Committee, ICB Board and the ICB Audit and Risk Committee.
Next steps/ onward reporting	Future financial and risk updates will be given to the ICB Board, ICB Finance, Performance and Investment Committee, ICB Audit and Risk Committee and place based partnerships
Conflicts of interest	No conflicts of interest.
Strategic fit	Which of the ICS aims does this report align with? • To enhance productivity and value for money
Impact on local people, health inequalities and sustainability	Update of financial sustainability and performance of the system.
Impact on finance, performance and quality	Delivery of the financial plan and meeting the control total and delivery of performance metrics and constitutional standards are mandated requirements.
Risks	The main risks flagged across the system are inflation, non-delivery of efficiencies, industrial action, operational pressures and lost income for providers. The ICB risk rating for finance is 20.

APPENDIX 1

NHS
North East London

Month 7 2023-24 Finance Overview

Meeting name: B&D HWB/ICB Committees in Common

Presenter: Sunil Thakker

Date: 16 January 2024

Executive Summary - Finance

Month 7 ICS Position - YTD £93.1m deficit variance against plan.

The ICS has reported a year to date deficit at month 7 of £93.1m. This gives an adverse variance to plan of £87.2m.

The main drivers are inflation, under delivery of the efficiency target, staffing (including agency usage), industrial action and other run rate pressures.

Month 7 I&E - YTD - ICS

		YTD	Forecast
Target	£m	(6.0)	0.0
Actual	£m	(93.1)	0.0
Variance Surplus / (Deficit)	**£m**	**(87.2)**	**0.0**

Financial Risks to the ICS Forecast outturn.

Gross risks across the system of £184m.

Main drivers – inflation, efficiency risk, run rate risks and income risks to providers.

The net risk is £54.9m. This assumes £129.1m of potential risk will be mitigated.

ICS Risk

		Gross Risk	Post Mitigations
System wide risks	£m	(184.0)	(54.9)
Operational improvements and recurrent mitigations	£m	0.0	0.0
Non Recurrent mitigations	£m	0.0	0.0
Total	**£m**	**(184.0)**	**(54.9)**

NEL ICB – YTD deficit variance of £16.5m against plan.

The ICB planned year-to-date surplus of £9m. The year-to-date reported position is a deficit of £7.5m which gives an adverse variance to plan of £16.5m. At month 7 the ICB has hit the financial recovery plan (FRP) trajectory.

The ICB run rate pressures, largely relate to prescribing and mental health and under delivery of efficiencies.

Month 7 I&E NEL ICB

		YTD	Forecast
Target	£m	9.0	15.4
Actual	£m	(7.5)	15.4
Variance Surplus / (Deficit)	**£m**	**(16.5)**	**0.0**

ICS Delivery of Efficiencies

Year-to-date efficiency plan across the system of £146.5m. Actual delivery of £121.7m, resulting in under delivery of £24.8m.

Efficiencies have been recategorized in the ICB to include those that are cash releasing. Non cash releasing efficiencies are included in the FRP stretch.

Under delivery is expected to continue year end with forecast slippage of £40.4m.

ICS Efficiencies

		YTD	Forecast
Target	£m	146.5	277.8
Actual	£m	121.7	237.4
Variance	**£m**	**(24.8)**	**(40.4)**

NEL ICS - Financial Summary Month 7

Surplus / (Deficit) - Adjusted Financial Position

	YTD Surplus / (Deficit)			Full Year Forecast Surplus / (Deficit)		
	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
North East London ICB	9.0	(7.5)	(16.5)	15.4	15.4	(0.0)
Providers	(14.9)	(85.6)	(70.7)	(15.3)	(15.3)	0.0
ICS Total	**(6.0)**	**(93.1)**	**(87.2)**	**0.0**	**0.0**	**0.0**

Month 7 Summary Position

- The year-to-date ICS position against the plan is a **deficit of £87.2m**. This is made up of a provider deficit of £70.7m and ICB deficit of £16.5m.
- In line with the operating plan and the national reporting protocol the forecast position at month 7 is **reported as a breakeven position**. This assumes that providers will deliver a planned deficit of £15.3m and the ICB will deliver an offsetting surplus.
- However, as reported in previous month the year-to-date position suggests there is a **risk of a year-end deficit**. This has resulted in a formal Financial Recovery Plan (FRP).
- The FRP shows **potential system gap at year-end of £54.9m**. Since month 7 reporting NHSE has indicated that there will additional funding for industrial action and non-recurrent measures and have requested that systems submit an updated forecast position. NEL ICS has submitted a return that shows a month 12 forecast deficit of £31.2m.

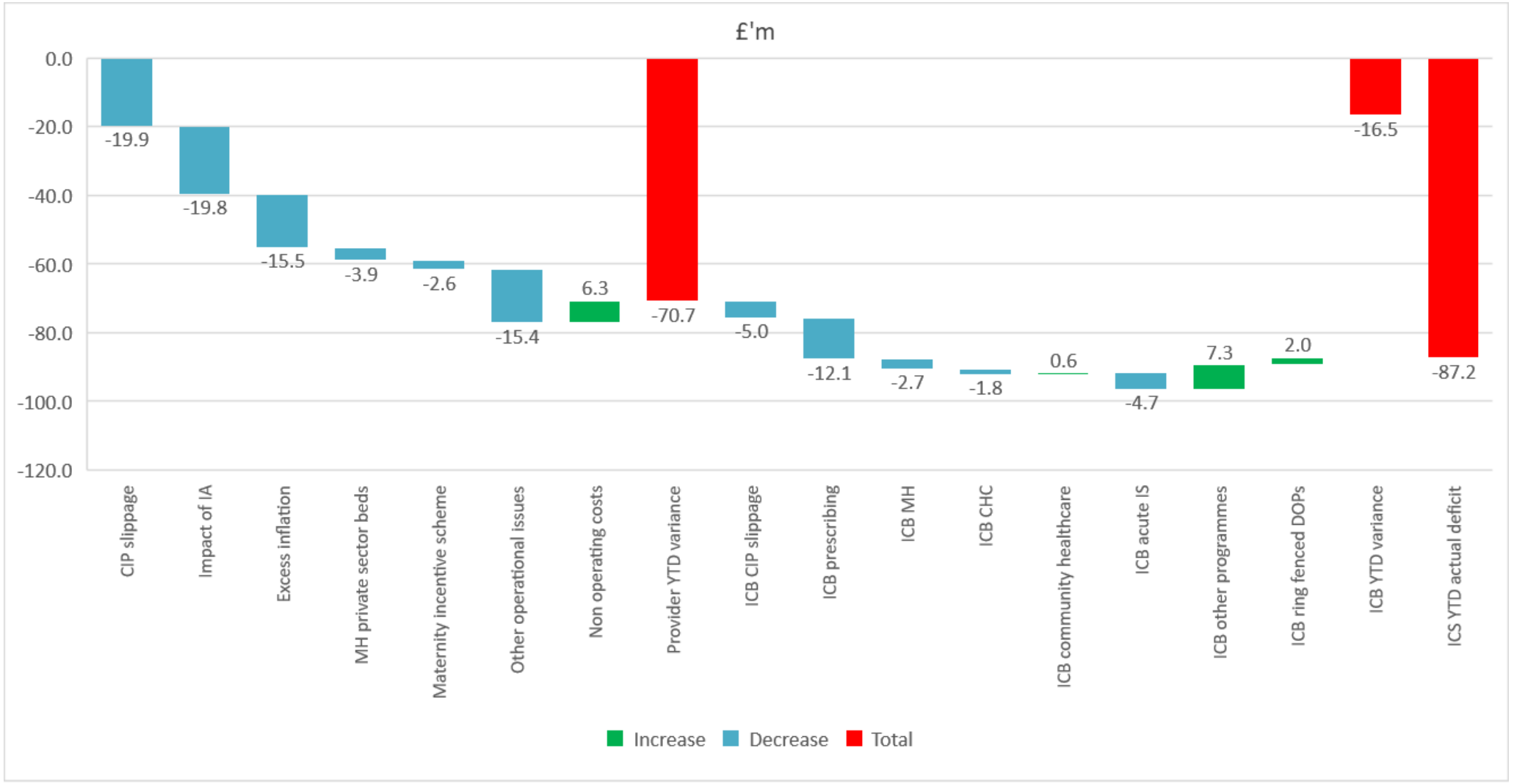
NEL ICS Financial Summary Month 7

Organisations	Year to date			Reported Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
BHRUT	(3.5)	(27.5)	(24.0)	(0.2)	(0.2)	0.0
Barts Health	(16.2)	(49.8)	(33.6)	(27.8)	(27.8)	0.0
East London NHSFT	1.1	(3.2)	(4.3)	5.4	5.4	0.0
Homerton	0.1	(8.4)	(8.5)	0.2	0.2	0.0
NELFT	3.5	3.2	(0.3)	7.0	7.0	0.0
Total NEL Providers	**(14.9)**	**(85.6)**	**(70.7)**	**(15.3)**	**(15.3)**	**0.0**
NEL ICB	9.0	(7.5)	(16.5)	15.4	15.4	(0.0)
NEL System Total	**(6.0)**	**(93.1)**	**(87.2)**	**0.0**	**0.0**	**0.0**

Month 7 Summary Position

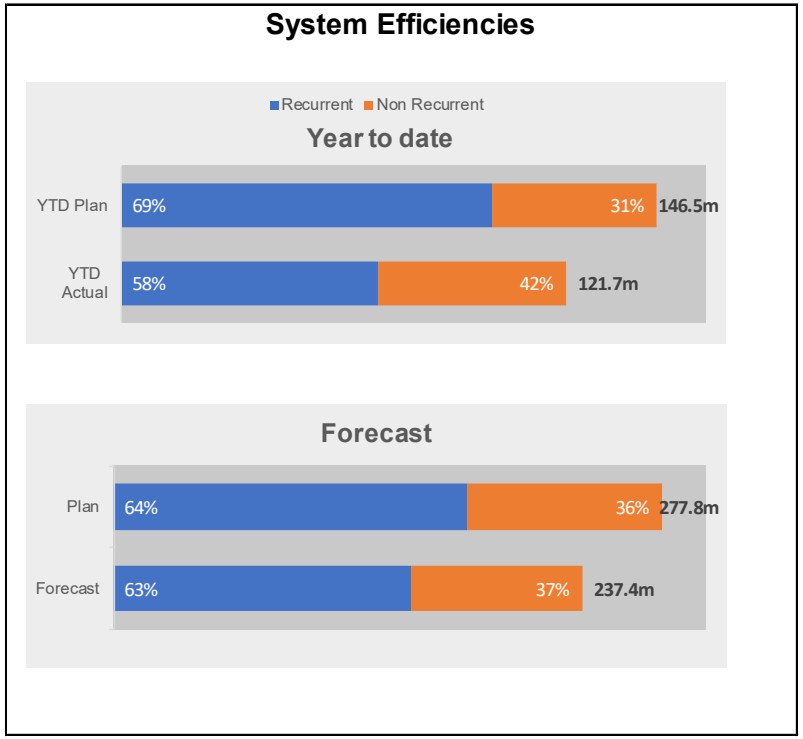
- One of the main drivers of the ICS position is a year-to-date under delivery against the efficiency target. The total year-to-date position on efficiencies is an under delivery of £24.8m, with expected year-end slippage of £40.4m.
- The ICB overspend is driven by under delivery of efficiencies and run rate pressures in prescribing, mental health and CHC. The run rate pressures are driven by a combination of volume growth and price increases. Within the forecast position the ICB has assumed that it will deliver £103.4m cost improvement schemes and additional FRP stretch measures. This is a stretching target with an increase in delivery expected in the remaining five months of the financial year. Delivery of savings from month 8 onwards is expected to be in excess of £13m per month.
- Provider efficiency slippage accounts for £19.9m of its reported overspend. System providers are also reporting pressures in relation to inflation, industrial action and staffing (including pay awards and agency usage).
- In terms of agency usage system providers are exceeding the agency cap set by NHSE for 23/24. The annual agency cap is set at £140.6m. Month 7 year-to-date spend on agency is £113m (80% of the cap). The extrapolated run rate suggests that provider outturn spend on agency could be in the region of £194m. However, providers are expecting to put corrective measures in place and have reported forecast agency spend of circa £159m (£18.6m above the cap).

NEL ICS - Summary of Month 7 YTD Variance



System Efficiencies – Month 7 and Forecast

- The total year-to-date planned efficiency target for the NEL system is £146.5m and the forecast target is £277.8m.
- The year-to-date efficiencies delivered across the system is £121.7m, resulting in under delivery against the target of £24.8m.
- Delivery of efficiencies is a major risk to the system and there was a slow start to the delivery of efficiency schemes. The FRP has detailed a stretch to existing schemes which will improve the delivery run rate. It is, therefore, expected that there will be improvements in the identification and delivery of efficiencies over the remaining months of the financial year.
- At year-end the ICB is forecasting under delivery against the efficiency target of £18m, with providers expecting under delivery of £22.4m. The total year-end position is a forecast under delivery of £40.4m.
- The information on the right is based on information submitted to NHSE from ICB data sources and provider financial returns. The chart shows the proportion of recurrent and non-recurrent schemes both in terms of the plan and actual performance.



Efficiencies	Year to date			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Total Provider Effieciency	**108.6**	**88.8**	**(19.9)**	**195.2**	**172.8**	**(22.4)**
NEL ICB	37.9	32.9	(5.0)	82.6	64.6	(18.0)
Total System Efficiency	**146.5**	**121.7**	**(24.8)**	**277.8**	**237.4**	**(40.4)**

ICS – Month 7 Performance and FRP Trajectory

Organisation		FRP		Industrial Action (IA) Impact	
	M1-7 Actuals £m	FRP Expected M1-7 Actuals £m	Variance from FRP £m	M1-7 Adjusted Actuals (IA) £m	Adjusted Variance from FRP £m
BHRUT	(27.5)	(17.6)	(9.9)	(24.6)	(7.0)
Barts Health	(49.8)	(42.0)	(7.8)	(41.9)	0.1
East London NHSFT	(3.2)	(1.8)	(1.4)	(2.9)	(1.1)
Homerton	(8.4)	(6.7)	(1.7)	(7.1)	(0.4)
NELFT	3.2	3.5	(0.3)	3.5	(0.0)
Total NEL Providers	**(85.6)**	**(64.5)**	**(21.0)**	**(73.0)**	**(8.4)**
NEL ICB	(7.5)	(7.6)	0.1	(7.5)	0.1
NEL System Total	**(93.1)**	**(72.2)**	**(20.9)**	**(80.5)**	**(8.3)**

- The FRP trajectory requires an improvement on the monthly run rate position, with an expectation of an in-month breakeven position from month 7.
- In month 7 the system financial performance was £20.9m above the FRP trajectory.
- However, industrial action has impacted on the overall financial position. Removing the costs of industrial action from the month 7 year-to-date position results in adjusted year-to-date actual deficit of £76.4m. At month 7 the FRP trajectory expected year-to-date deficit of £72.2m. This means that the system is effectively £8.3m adrift from the FRP trajectory. The adjusted position is dependent on the costs of industrial action being covered by an additional funding source.

ICS – Revised Forecast Outturn Summary Table

	ICS £'m	BHRUT £'m	Barts £'m	ELFT £'m	Homerton £'m	NELFT £'m	ICB £'m
FRP	**-54.8**	**-14.2**	**-55.5**	**5.4**	**-5.1**	**7.0**	**7.5**
Revised FOT	**(31.2)**	**(14.2)**	**(42.6)**	**5.4**	**(1.9)**	**7.0**	**15.1**
Movement from FRP	23.7	0.0	12.9	0.0	3.2	0.0	7.6

Original plan	0.0	(0.2)	(27.8)	5.4	0.2	7.0	15.4
Movement from plan	(31.2)	(14.1)	(14.8)	0.0	(2.1)	0.0	(0.2)

- The return to NHSE shows a revised system deficit of £31.2m. This has been agreed with system partners as a realistic year-end forecast.
- The movement from the FRP is as a result of the £31m additional allocation for industrial action and non-recurrent measures and an assumed £8.4m benefit as a result of a 2% ERF threshold adjustment.
- Other assumptions included in the revised forecast include;
  i. The underspend on delegated budgets for dental can be included in the revised forecast as a benefit to the bottom line. This is in the region of £10m.
  ii. Subject to some exceptions underspends against SDF will be able to be used non-recurrently to support wider system financial performance.
  iii. It is assumed that the level of efficiencies and FRP stretch required to deliver this position will remain in line with the value reported at month 7
- Providers have made an assumption of the financial risk of continued industrial action. This is estimated to be £23m and would impact the system's ability to hit the revised forecast position.
- From an ICB perspective the revised forecast outturn assumes increased funding over and above funding assumed as part of the FRP. Therefore to deliver this position the ICB will need to deliver its FRP plan in full.

Better Care Fund (BCF) 23-24

- A paper was presented to Barking and Dagenham Place to note and virtually sign off the BCF.
- The total BCF funding available, including additional discharge funding is £33.7m.
- The NHS additional funding of £295k relates to ageing well funds.
- The LA and ICB are required to submit regular reports to NHSE on the 23/24 discharge funds. Updates on this spend is given in this reporting pack.

- Details of the schemes funded by the NHS minimum contribution are shown in the bottom table.
- A breakeven position was shown on these schemes at month 7.

	23/24 Allocation £
Disabled Facilities Grant	1,856,901
Improved Better Care Fund	10,707,003
NHS Minimum Fund	18,440,057
NHS Additional Funding	295,000
LA Additional Funding	0
Local Authority Discharge Fund	1,501,105
ICB Discharge Funding	890,553
Total	**33,690,619**

	23/24 Allocation £
Carers of B&D	56,422
IPS - (vocational/employment Support Service)	230,064
AGE UK (Falls)	12,253
AGE UK (AFS Care Navigator)	15,471
NELFT	9,474,451
Reablement	1,098,708
BCF Social Care	5,621,327
BCF Care Act	694,827
Care Home Trusted Assessors	18,590
Hospital Dischrage service (NELFT)	410,570
Home first (NELFT)	114,658
Ageing Well (NELFT)	298,296
Falls Community - NELFT	220,738
St Francis Hospice	173,682
Total NHS Funding	**18,440,057**

BCF Discharge Funding Update

Discharge Fund 2023-24	
Income Allocation	**£**
B&D	1,501,105
ICB	890,553
TOTAL	**2,391,658**

Expenditure Allocation	Project	Plan £	YTD Actual £	Forecast Spend M8-12 £
Hospital discharge, planning and support	Commissioning project management to support Discharge Fund initiatives	80,000		80,000
Hospital discharge, planning and support	Support for complex discharge cases	150,000		150,000
Targeted out of hospital care	Unfunded homecare and crisis intervention packages	665,000	665,000	-
Targeted out of hospital care	Unfunded residential, nursing and supported living placements	803,105	803,105	-
Targeted out of hospital care	Unfunded reablement packages	618,000	300,000	318,000
Hospital discharge, planning and support	Workforce support	75,553	75,553	-
TOTAL		**2,391,658**	**1,843,658**	**548,000**

- The discharge fund is used to support the system with hospital discharges.
- The monies support the local authority to plan and implement measures to support the reduction of delayed discharges. Post-holders have been recruited to manage complex cases in the mental health cohort.
- Short term care packages are purchased (pathway 2 clients) seeking to improve and maximise reablement opportunities and independence of residents are also utilised and spend here is fully allocated. Demand for care grows and shortfalls are met from the councils existing budgets.
- Clients who are not fit to be discharged to their normal place of residence make use of the residential based care and this is on track to be fully spent, with a pressure due to the acuity of need of clients coming out of hospital.
- The discharge funds continues to be used to support and reduce the total number of delayed discharges.

BCF Ageing Well Schemes

Project	Lead	£
High Intensity Users	ICB	-
Social Isolation and hospital discharge work with	LBBD	100,000
Cost of Living	LBBD	-
Proactive Care	ICB	350,000
OT retention of staff	LBBD	41,000
Project Manager	ICB	69,680
Blue Band pilot	ICB	-
Care Home Medical Escort	ICB	-
Carers Identification	LBBD	15,000
Total		**575,680**
Amount left to be allocated		- 47,185

- The ageing well budget is made up of 23/24 budget of £295k allocated through the BCF and brought forward budgets from prior years.
- The ageing well funds have been allocated and are largely on track with spend.
- The social isolation project which seeks to reduce the number of visits made by regular attendees or those facing social isolation - currently, in the stages of design a community grants round is imminent to pilot a programme of small initiatives to assess impact on reducing social isolation among regular hospital attendees.
- 15k for hidden carers training has been spent – used to identify hidden carers e.g. through hospital and better support them to support their loved ones
- The OT project has been used to overhaul and improve our pathways and has overspent – with a shift from the project manager role to cover. This is critical as we have identified ways to improve systems to ensure a faster response to service users.

Demand and Capacity Funding

Project	Plan £	YTD Actual £	Forecast Spend M8-12 £
2 x Social Workers	76,181.96		76,182
Occupational Therapist	50,787.97		50,788
Equipment & Care Tech	203,152.00		203,152
Extra Care	42,323.00	130,000.00	- 87,677
Housing Support - Blitz Clean	16,929.32	16,929.32	-
Additional Nurs, Res, Homecare Packages	211,616.55	211,616.55	-
TOTAL	**600,990.80**	**358,545.87**	**242,444.93**

- The total allocation for LBBD for demand and capacity is £601k. It is expected that this will be fully utilised by year-end. This budget is non-recurrent and will not be available in 2024/25.
- The fund bolsters the ability of the system to provide support during peak winter times. In particular, it is being used to increase social care and occupational therapy capacity.
- Additionally, there are funds for equipment, in particular technology and equipment to help keep people at home and free up bed capacity in hospitals.
- There is also extra support through discharge flats located in extra care settings – providing additional support to residents who are not quite ready to move back home and need a bit more oversight and care support. There is also a small amount that goes in to support people who need help with decluttering, blitz-cleaning and the first steps of moving back home.
- In addition we have some money to support with the increase of care packages that comes in this peak time.

Section 256 - Health Inequalities Funding

Project	Plan £	YTD Actual £	Forecast Spend M8-12 £
Community Infrastructure Development/ Locality Leads model	215,000	215,000	-
Workshops for early years professionals around Family Hubs/ Partner Networks in Practice	15,000	15,000	-
Learning set for PCN Health Inequalities Leads	10,050	5,025	5,025
Trauma-Informed Practice for Adult Social Care	3,580		
System wide workshops	12,370	-	15,950
Social prescribing 'community chest'	48,518	48,518	-
Social prescribing 'community chest'	2,482	-	2,482
Planning NHS services in community hubs	100,000	50,000	50,000
PCN Health Inequalities Leads capacity	75,000	75,000	-
PCN Health Inequalities Leads capacity (extension Apr - Aug 2023)	25,000		
Targeted debt support and health risks mitigation	140,000	50,000	90,000
Community-led support for people with no recourse to public funds pilot	65,000	65,000	-
Identifying and supporting residents with common preventable morbidities and risk of premature mortality (case finding)	115,000	-	115,000
Participatory grant making for CYP mental health	100,000	100,000	-
Locality-based integrated care MDT clinics for vulnerable 0-5 year olds/ Vulnerable Hot Clinic	50,000	50,000	-
Scoping system data needs	19,000	-	44,000
Evaluation	55,000	-	55,000
Project management	55,000	-	55,000
TOTAL	**1,106,000**	**673,543**	**432,457**

- The 23/24 agreed health inequalities funding from the ICB is £518k.
- The total budget includes the current year budget and brought forward underspends from the prior year.
- At month 7 £674k has been committed with the remainder of the allocation factored into the forecast spend.

NEL ICB – Discharge to Assess, Rehab and Equipment – Month 7 Update

Service Description	YTD Budget £	YTD Actual £	YTD Variance £	Annual Budget £	FOT £	FOT Variance £
D2A	333,004	379,072	-46,068	570,864	759,476	-188,611
Rehab	539,336	540,574	-1,238	924,581	1,002,093	-77,512
Equipment	138,439	260,231	-121,792	237,317	446,111	-208,794
TOTAL	**1,010,779**	**1,179,877**	**-169,098**	**1,732,762**	**2,207,679**	**-474,917**

- The total annual budget for Barking and Dagenham place for discharge to assess (D2A), rehab and equipment is £1m. This was based on 22/23 outturn and uplifted for the relevant planning uplifts.

- Based on the latest data there is a year-to-date reported overspend of £0.2 against these areas with an expected year-end overspend in the region of £0.5m.

- The drivers of the overspend are;
  i. Patients with higher levels of acuity which means the ICB is incurring 1-2-1 costs and higher cost domiciliary care packages for them to be supported at home
  ii. High cost rehab packages
  iii. Equipment overspend is based on the latest data and reflects the costs of equipment issued when residents are discharged to their homes.

HEALTH AND WELLBEING BOARD and ICB SUB-COMMITTEE
(Committees in Common)

16 January 2023

Title:	Draft Annual Report of the Director of Public Health 2022/23

Open Report	**For Decision**
Wards Affected: None	**Key Decision:** No
Report Author: Jane Leaman, Consultant in Public Health	**Contact Details:** matthew.cole@lbbd.gov.uk

Sponsor:
Matthew Cole, Director of Public Health

Summary:
Directors of Public Health have a statutory requirement to write an annual report on the health of their population.

This cover paper gives an overview of the draft Director of Public Health's Annual Report 2022/ 23 which informs local people about the health of their community, as well as providing necessary information for decision-makers in local health services and authorities on health gaps and priorities that need to be addressed. The DPH's draft Annual Report 2022/ 23 is attached at Appendix A.

Recommendation(s)

The Health and Wellbeing Board and ICB Sub-Committee are recommended to:
1. Provide any comments on the contents of the draft report set out at Appendix A.
2. Note the Public Health Advice provided within.
3. Support a discussion on taking forward the advice once the report is published.

Reason(s)

1. The report provides independent public health advice to the Place- based Partnership on the key priorities to deliver improved health and wellbeing in the borough, as identified in the Joint Local Health and Wellbeing Strategy, informed by the Joint Strategic Needs Assessment.
2. The report contributes to the Borough Manifesto vision: One Borough. One Community. No-one left behind.
3. The key messages within the report contribute to the delivery of all Corporate Plan priorities, particularly:
   - *Residents are safe, protected, supported at their most vulnerable.*
   - *Residents live healthier, happier, independent lives for longer*.

   And supports the following principles within it:
   - Work in partnership.
   - Engage and facilitate co-production.
   - Be evidence-led and data driven.
   - Focus on prevention and early intervention.

- Provide value for money.
- Be strengths-based.
- Adopt a “Health in all Policies” approach.

4. The report reflects the following priorities in the NHS NEL Joint Forward Plan- Long term conditions; mental health; maternity; babies children and young people and cancers.

1. Introduction and Background

1.1 To support a local government-led approach to better public health, every local authority with public health responsibilities must, jointly with the Secretary of State (SoS) for Health and Social Care, appoint a specialist Director of Public Health (DPH). The DPH is a statutory chief officer of their authority, accountable for the delivery of public health responsibilities, and the principal adviser on all health matters to elected members and officers, with a front-line leadership role spanning all 3 domains– health improvement, health protection and healthcare public health. The DPH also has a vital system leadership role, working closely with place-based organisations in efforts to secure better public health.

1.2 As part of this role of the Director of Public Health has a statutory requirement to publish an annual report which informs local people about the health of their community, as well as providing necessary information for decision-makers in local health services and authorities on health gaps and priorities that need to be addressed.

2. Proposal and Issues

2.1 The first chapter reflects on the DPH’s professional advice given over the last 10 years following Public Health’s transfer from the NHS to local authorities in 2013. Themes have been repeated from the evidence base in our pursuit of finding better ways to tackle the deep seated and entrenched inequalities in Barking and Dagenham

2.2 Ensuring good health and wellbeing and preventing the need for expensive health and social care is crucial in this financial climate, with funding pressures for all our system partners. The report advises we must therefore prioritise; focusing on impacts over the next five years on those interventions which will improve healthy life expectancy and address health inequalities and address the immediate demands of expensive health and social care services, as well as contributing to meeting the wider priorities of the council for example improving opportunities for employment, training and education.

2.3 In response to this, chapter 2 looks at how we can use the opportunities of the integrated care system at place to improve the health of our residents. Particularly how to transition the shared outcomes in our Joint Local Health & Wellbeing Strategy (JLHWS) 2023-28 into drivers for commissioning a whole systems approach. The key message is that we should exploit the opportunities we have in the Place-based Partnership to improve healthy life expectancy by:

- Agreeing shared outcomes and priorities.
- Aligning strategic plans, develop agreed delivery plans and outcomes of the locality model.

- Invest together on programmes to deliver our priorities and reprioritise our spending of the Public Health Grant.

2.4 Chapter 3 describes why we should focus on increasing healthy life expectancy and addressing those contributing factors which in the short term, impact on overall health, ability to live independently in later life, and on the increasing demand on our health and care system. It determines that is our approach is well structured, actions identified can provide results within the five years of the JLHWS.

To increase the number of years of our residents spend in good health, we should target our collective resources into:

- Enhancing our early diagnosis programmes, that target key groups of residents, supported by assessable and culturally appropriate chronic disease management programmes.
- Reducing high levels of smoking and obesity.
- Reducing mortality rates associated with cardiovascular disease and cancer.
- Addressing the variation in health and social care outcomes experienced within and between our communities in each of these areas.

2.5 Chapter 4 sets how and what we need to do to address the key contributing factors to health life expectancy i.e., addressing long term conditions, key behavioural risk factors and the wider determinants of health (developing the building block for good health).

To improve healthy life expectancy the evidence suggests:

- Taking a place-based approach to address early identification and early treatment for people with long term conditions:
  - to ensure all residents with a health condition are identified and are supported to manage their condition.
  - that addresses social, economic, and physical environment that causes our residents to make decisions that damage their health and lead to long term conditions, such as those driving obesity through unhealthy diets and lack of physical activity.
- Providing a targeted support programme to residents to address obesity and smoking.
- Addressing wider determinants of health for example to insulate and remove damp and mould in homes; support people with long term conditions or disabilities, including young people with special educational needs and disabilities to gain and stay in employment, and mitigate the health harms of the cost-of-living crisis.
- Improving mental health and wellbeing as an underpinning factor.

To address underpinning health inequalities, we need to:

- Develop a shared understanding of health inequalities, its drivers and local priorities (including across our population groups and geographic areas) to direct decision making and action.
- To align the NHS's mandated duty to address health inequalities with the overall place-based programme.

- Work with NHS North East London on their Healthy Equity Academy and their evolving Health Equity Fellowship (including extending beyond the NHS to create analogous community sector fellowships).
- Continue and expand cross-sector action on the ongoing health legacy of COVID-19 and impacts of the cost-of-living crisis that are increasing health inequalities for residents.
- Ensure a 'health in all policies approach' in which all systems partners are engaged to understand and address the role of health inequalities in driving community priorities (e.g., employment).

2.6 A large part of the report is focusing on actions which relate to adults and actions that can affect short term change, but action across the life course is important - today's children will be tomorrow's adults, and the things that happen to them in childhood can shape the trajectory of their health through to older age. Therefore, we need to maintain a focus for children to improve the health outcomes for our general population across the life course.

To do this chapter 5 provides data and evidence on the importance of strengthening our approach to giving children the best start in life, via universal support/prevention activities, early identification of emerging issues, and provision of timely help to support families, by maximising the opportunities of the 0-19 programme so it better links to the needs of the children and young people and the drivers of demands in Health and Social Care.

The Public Health advice is for the 0-19 programme to focus on the high impact areas of the Healthy Child Programme.

- Address the causes of Adverse Childhood Experiences including Domestic Abuse and parental mental ill-health.
- Support for our vulnerable children to thrive in their home and school environment - focusing on:
    - school readiness (0–5-year-olds)
    - a better offer for those with social, emotional, and mental health needs (5–19-year-olds);
    - opportunities to identify and address neglect.

2.7 Protecting residents from communicable diseases remains one of the DPH's core statutory responsibilities, with the public health system working together to manage and prevent serious notifiable diseases and outbreaks. The most important function is the containment of notifiable infectious diseases.

Chapter 6 describes how COVID-19 has changed the way health protection issues are addressed –for example we recognise the importance of all communities having access to vaccinations and we now seek to understand and address why people are hesitant to take up opportunities to protect their health. Furthermore, as was identified in the Public Health England report[i], people who have poorer health e.g. living with one or more long term condition, had less resilience and were more likely to become seriously unwell compared to others.

This chapter focuses on the importance of vaccination and immunisations including improving the uptake of the MMR vaccination due to the rise in measles cases in England.

To support this action the public health advice is for:

- Our Place Based Partnership to prioritise childhood immunisation to improve and reduce the differences of uptake within our communities.
- Enough investment to improve the uptake of vaccinations- specially MMR, reduce the inequity of uptake and to introduce the chickenpox vaccination if directed, following recommendations of the Joint Committee of Vaccinations and Immunisations.
- Communications strategies that are simple and hard-hitting, with continuous messaging on the importance and benefits of vaccination.

3 Consultation

Following initial discussion of the draft at the Committees in Common and prior to publication, this report will be presented to the Barking and Dagenham Executive Group and LBBD Executive Team.

Please note that references will be included within, once the report is considered final.

4 Mandatory Implications

4.1 Joint Strategic Needs Assessment

The report due on the needs identified in the JSNA (2022) and will inform the data provided within the JSNA (2024).

4.2 Health and Wellbeing Strategy

This report provides public health advice on how to take deliver the outcomes set out in the Health and Wellbeing Strategy.

Public Background Papers Used in the Preparation of the Report: - None

List of Appendices:

Appendix A - Draft LBBD ADPHR 2023

[i] Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities (publishing.service.gov.uk)

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APPENDIX A

Annual Director of Public Health Report 2022/23

Living Longer; Living Healthier

– a focus on prevention and early diagnosis

Barking & Dagenham

Foreword

Preventing ill health has obvious benefits, a person who is in good enough health is likely to be happier, to keep in work, to pay taxes, not to require welfare or social care support, and to be able to support others.

A Covenant for Health, 2018

Welcome to the Director of Public Health's Annual Report for 2022/23. The last year has been challenging for many residents due to cost-of-living pressures and these have impacted on health and wellbeing in many ways. Our health and social care system remains firmly in the eye of the inflationary storm and severe funding and demand pressures mean that NHS and council finances are under pressure like never before. Simply put we can no longer afford to meet the rising needs of our population by spending more money on the kinds of services we currently provide.

Against this backdrop as Director of Public Health, it is my responsibility to describe and advocate how we can improve health through a lens that's wider than traditional health and care. This is challenging at a time when we need resources to keep pace with need and, dare I say it, a levelling up of resourcing!

Over the next 12 months we will be rethinking how we deliver public services to address the scale of the financial savings to be made while the borough's population continues to increase. Our Integrated Care System arrangements have now been established with our Health & Wellbeing Board and Integrated Care Board Sub Committee forming a groundbreaking Committees in Common. This arrangement will provide the leadership and oversight to ensure the collective efforts of all our partners are focused on delivering the shared outcomes in our Joint Local Health & Wellbeing Strategy 2023-28 and closing the gap for those with the poorest outcomes.

Central to realising the opportunities of 'Place Leadership' is the need to change the engagement relationship between our residents and the council as well as between patients and the NHS to determine the way we provide services where the best outcomes can be delivered at the right cost. The partners recognise that whatever the solutions, it is increasingly clear that the future depends on a much closer working relationship with residents and communities focused on the neighbourhoods in which they live.

As we know services on their own will not improve our agreed public health outcomes or manage health and social care demand without a radical upgrade in prevention that addresses the wider social determinants of health. Real world evidence tells us that approximately 20 per cent of a person's health is dependent on the healthcare services they receive. The other 80 per cent is accounted for by what is known as the social determinants of health.

The World Health Organisation states that "the social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and poor quality one. Social determinants of health include experience during the early years, education, working conditions, income, housing, communities and environment, and discrimination and exclusion".

We now need to apply a laser-like focus to improving population health, be clear where our inequalities in outcomes within and between communities are, for example by providing opportunities for children suffering from neglect or actions to improve access to mental and physical health services for those with mental health conditions. There is much still to do, but the guiding principles should be for tangible actions that inspire residents in terms of what we can achieve and to gather enough meaningful actions so we can see that the sum of these actions leads to real change. Without this we risk piecemeal and inconsistent activities that are not enough to make a real difference.

My report gives a professional perspective that informs this approach based on sound evidence and objective explanation, taken mostly from our 2022 Joint Strategic Needs Assessment. I hope my observations in the following chapters act as a starting point for identifying 'where to look' before 'what to change' and finally 'how to change.'

In Chapter 1, I reflect on my professional advice given over the last 10 years following Public Health's transfer from the NHS to local authorities in 2013. Themes have been repeated from the evidence base in our pursuit of finding better ways to tackle our deep seated and entrenched inequalities. Providing comments on how Best Value may be achieved has been at the centre of my reports. This has led me to provide focused advice on realising the ambitions of new models of care and meet the transformation targets of the council and NHS that require us to work beyond traditional organisational boundaries. Underpinned by the need for local determination around resources and ensure that we are cleverly using data to effectively manage demand and prioritising human relationships in the way we connect with residents.

Chapter 2 examines the next steps in using the opportunities of the integrated care system at place to improve the health of our residents. Particularly how we transition the shared outcomes in our Joint Local Health & Wellbeing Strategy 2023-28 into drivers for commissioning a whole systems approach. This will help to widen the reach and impact of our combined partnership resources by overcoming the challenge of individual partners focussing on their own organisational priorities dominated by measuring inputs and outputs. A better understanding both of what matters to people, and what works will reinforce our shared efforts to meet national outcomes and regulation requirements.

Part of this ask is to streamline the complexity of the integrated care system that by design has developed 'systems within systems' to focus on various aspects of performance, transformation, and access, drawing on skills and services from across the partnership. The challenge is to ensure that activities of separate groups form part of a coherent, mutually reinforcing approach, rather than becoming a disjointed set of initiatives.

Chapter 3 examines our understanding of the data to support the prioritisation of long-term conditions based on prevalence and the variation in outcomes between our communities which is critical to our ability not only to improve healthy life expectancy but also for population health management.

Focusing on the long-term conditions that are driving our health and social care demand is essential to how we effectively manage the local system. Early intervention and diagnosis are critical to deal with issues before they impact negatively on a person's health and wellbeing and the wellbeing of the community. The answer to improving healthy life expectancy is not solely a medical one its one that integrates our primary care and secondary care disease management programmes with council and voluntary and community sector services.

In following reports, I have focused on the need for continuous improvement in addressing the borough's widening health inequalities and the need to have ways of working that target residents through their networks and where they are to further our efforts in closing

the gap. Chapter 4 examines how we can do this. Better use of data and community insight will enable us to focus down on where the variations in outcomes exist and identify those variations that that have an uneven impact on healthy life expectancy, thus targeting our resources proportionate to need.

Setting a small number of strategic inequality outcome measures linked to the shared outcomes in our Joint Local Health & Wellbeing Strategy 2023-28 would be helpful in bringing clarity on what variation we are targeting. This can then be built into a coherent narrative through strategies, plans and communications. Key to this is the enhanced ability to systematically measure performance against variation as well as gaining a deeper understanding of the risk and protective factors for vulnerable groups across the life course. This will provide a more powerful mechanism for embedding an integrated approach to tackling health inequalities.

Chapter 5 takes forward the commitment in last year's report to undertake an in-depth review of our 0-5 (health visiting) and 5-19 (school nursing) services. The review was timely as the Department for Health released revised Healthy Child Programme Guidance on 27th June 2023, which aligns outcomes with the Family Hubs programme.

The review recommended that consideration is given to reviewing investment levels, service change (including the impact of reduced services elsewhere) and innovation to improve the outcomes of children's public health services. This is to ensure that our service offer is reflective of the changing demographic profile of the borough and delivery of the Healthy Child programme, including the universal mandated elements.

In the closing chapter, I discuss the significant efforts into promoting the importance of vaccination, mainly amongst groups with the lowest uptake, greatest vulnerability, and lowest vaccine confidence. Childhood immunisation uptake continues to remain a concern due to performance remaining below national uptake target levels. Poliovirus detection in London and decreases in MMR vaccination uptake pose a particular concern for child health.

As for the challenge of winter, we know that vaccine hesitancy remains a big issue. For flu, the personal risk perception is likely to have reduced following limited case numbers in recent seasons. For COVID-19, learning to live with the 'new normal' may also lead to lower interest.

Later this year we will publish the refreshed Barking and Dagenham Joint Strategic Needs Assessment. This will provide an overview of the local data and insights that will both support the understanding of the key local population health needs that I highlight in this report and inform a partnership approach to reduce health inequalities and improve healthy life expectancy.

I hope you enjoy reading this report as well as finding it of interest and value.

Matthew Cole
Director of Public Health
London Borough of Barking and Dagenham

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Chapter 1:
Back to the Future

It has been 10 years since public health responsibilities moved into local authorities, and therefore I feel this is an opportune moment to look back and learn from what has happened.

Interestingly, over this time, the landscape of commissioning and providing social care, health care and public health, has considerably changed through government policy. However, several issues remain as significant today, such as the importance of place; strong relationships with residents; a vibrant voluntary sector; and integrated services to deliver health outcomes. But most importantly, poor health and profound health inequalities persist, with a very worrying trend in infant mortality getting worse in most deprived communities partly by the cost of living crisis.

Changes in outcomes take years to happen (the Health Foundation report highlights it can take up to 10 years to see changes in health inequalities) and be seen in the data, but data published this year from Census 2021 improves our understanding of relevant factors. The Census provides the most accurate data on changes over time of key determinants of health and health inequalities (population and households, housing, employment, health, education and transport).

Key findings and comparison for the borough, versus other areas of England and Wales between 2011 and 2021 include:

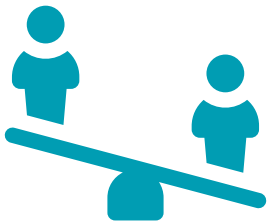
- *Rapid population growth* – 3rd highest increase in ten years (17.7%)
- *Young population* – Highest proportion (26.1%) of residents' under-16 years old
- *Deprivation* – Highest proportion of households (62.4%) deprived for education, employment, health or housing
- *Household structure* – 4th highest average household size (2.96%), highest lone parent households (12.8%) and 2nd highest multi-family households (8.6%)
- *Employment* – 3rd highest proportion of adults who had never worked (42%) and highest proportion who work offshore, in no fixed place or outside the UK (22.4%)
- *Disability within household* – Highest proportion of households in London with a disabled resident (29.8%)
- *Change in diversity* – Highest increase in residents born outside the UK (10.4%) and greatest increase in ethnic diversity (including highest proportion of Black African and 4th highest proportion of Asian Bangladeshi residents, 16.0% and 10.2%)
- Compared to the 2011 Census, a lower proportion of residents considered themselves to be in either *bad health or very bad health* – mirrored in London and nationally
- After accounting for age, Barking and Dagenham is higher than both London and England in terms of residents with *fair, bad and very bad health* in 2021

The Office for Health Improvement and Disparities Health Inequalities Dashboard also highlights:

- *Healthy life expectancy and life expectancy* has reduced in males and for females (although not significantly)
- Under 75 year old mortality rates for *cardiovascular disease* has gone up, but under 75 year old mortality rates for **cancer** has reduced (although neither are big changes)
- Suicides have increased (though not majorly)

Firstly, it should be recognised that many of these changes and characteristics (e.g. diversity, youth etc) bring benefits to our communities. Yet the pace of population change often brings big challenges for services and communities, e.g. an analysis of London house prices and life expectancies between 2002 and 2019 suggested areas with low house prices and rapid inflow of people have seen growing inequality in life expectancy[1]. A recent NHS North East London profile of the demography of north east London highlighted that Barking and Dagenham is expecting the greatest population growth in north east London of 37% (83,000) respectively by 2041. The largest growth will be seen in Barking Riverside where major development is planned to provide 10,000 new homes to house an additional 55,000 people – this is equivalent to growth of 520% of the current ward population.

This sets the context of my look back at the themes of my annual reports of the last decade.



Making the Healthier Choices, the Easier Choice for All

In 2013 I set out my challenge to make healthier choices the easier choice for all, which required supporting people to stay healthier; joined up and high-quality care; protecting people's health and providing care and support of children.

Now, 10 years on, the focus of this report has not changed. There remains a high burden of ill health (high mortality, coronary heart disease, cancer and respiratory disease); the need to continue to develop primary and social care to provide better care outside the hospital. If these services are going to be unsustainable, they need to effectively manage the demand pressures of the rapidly changing population. Keeping pace with changing needs and numbers must be at the forefront of partnership planning. As well as the knowledge that many healthy choices have become even harder, for example the diet meeting the Eatwell guidance is less affordable.

Obesity remains one of the biggest public health problems, still needing a system wide approach to tackle. Alongside other health improvement areas such as reducing smoking and improving mental health and wellbeing, the newly formed place-based partnership provides the best chance for this to now happen, alongside the commitment of the council to develop a 'Health in All Polices approach within its Corporate Plan. This recognises the role of green spaces, active travel and transport, access to training opportunities and good quality jobs and healthy homes has on health. The transfer of Public Health responsibilities in 2013 allowed the council to take a population focus as democratic stewards of local population well-being; shaping services to meet needs including environment; influencing wider social factors of health; and tackling health inequalities by taking strategic action across several functions e.g. housing, economic and environmental regeneration.

My call for a focus on good mental health 'as everybody's business' also remains a key building block for good health and enables people to participate in society, not least because good mental health is positive to the economy – people are less likely to be in employment or take more days off sick.

The need for better interventions to improve early years outcomes in the first five years - through the healthy child (0-5) programme was back in 2013 supported by the Family Nurse Partnerships and Troubled Families Programme, but we now have the opportunity through the re-procurement of 0-19 healthy child programme, the development of the family hubs and early start programmes.

The high numbers of early deaths identified in 2013, are still based on a high level of residents with long term conditions (LTCs) which need planned and proactive management, including optimum case finding to reduce need for hospital admissions and primary and social care support.

In 2014, The NHS Five Year Forward view was published which marked a radical upgrade in prevention, promoting crucial partnership between NHS and council, and the Transforming Primary Care in London programme set the context for better coordinated, accessible, and proactive care - focusing on health and well-being, which remains, alongside the integration of health and social care. At this time, we were working across a three-council footprint Barking Havering and Redbridge, which has now moved to be more localised with the formation of borough-based Place based Partnership, enabling our elected members and residents to have a stronger voice in decision making for their communities.

Growing the Borough to Improve Health

Throughout the years I continued to bring a focus back to the role of Place to grow the borough to improve health – demonstrating the opportunities of its regeneration plans, for example through the aspirations of the Barking Riverside 'healthy new town' proposal, recognising the broader role the council has in improving the public's health:

Growth and regeneration provide an opportunity to develop and use community assets, strengthen partnerships between communities and service providers.

Focusing on What Matters and Reframing Health Challenges

Reports 2015/16 and 2016/17 continued to focus on:

- Diagnosing illness early and managing it well including increasing breast, cervical, and bowel cancer screening uptake and identifying cardiovascular disease risk factors via the NHS Health Check, supported by a drive to reduce variation of quality of primary care by reshaping models of care pathways.
- Prevention to help residents to maintain their independence and reduce the risk of needing care or support, or delay the need for increased care and support, emphasised in the Prevention and Care Act 2014.
- Continued widening of health inequalities and together with the increase in long term conditions; action driven by the acknowledgement that we can no longer afford the services as they are by *not doing more but doing things differently or even stop doing something.*
- The need for a proper and robust framework around spending choices of the Public Health Grant to ensure effective use of the grant against agreed health outcomes with: *Better quality data on activities cost and outcomes to assess performance is required.*
- Importance of evolved power to commission and deliver against locally shared health and care outcomes, the delivery of integrated health and social care pathways, and the concept of place-based working in localities through the new model of care proposed through Accountable Care Organisations.

All of which at the time were captured in the new Sustainability and Transformation Plan.

The council's 2020 ambition to address the funding gap it faced was started, through which I identified the need for programme of change to tackle health inequalities through reducing smoking, improving blood pressure and cholesterol control and a focus on secondary prevention (detection of undiagnosed LTCs i.e. reducing numbers not included on GP monitoring lists, increase drug and lifestyle management and improving and reducing variations in cancer screening uptake, which developed different strategies to meet the different health needs of our population). It also needed to focus on requirements for a 'best start in life' including a reduction in newborn and infant mortality, providing good quality antenatal care, delivery and postnatal care including increasing vaccine and breastfeeding uptake, increasing well-being education, improving the goals of young people.

In **2015/16** I also first reported that pandemic influenza was the biggest communicable disease threat to the health of the population, but not even I could have foreseen the level, depth, spread and impact across the globe that the COVID-19 pandemic would have. Both directly on how death rates were unequal across communities and the indirect impact of the public health measures that we introduced at the time. And the ongoing negative impact on mental health, especially of children and the experiences of long COVID throughout the population. The pandemic has also changed the way we work on health protection issues today. I return to this in this report.

Creating Health

In **2018/19** I introduced the importance of improving healthy life expectancy - with the desire for residents to live longer in good health. I acknowledged that interventions that seek to change behaviour – won't work without understanding the specific needs of the population and addressing wider social and environmental constraints on choice – system wide working is paramount. The focus of my report today, builds on this by emphasising if we address factors which impact on healthy life expectancy in the short term; for example, managing LTCs this would have a direct link to reducing demand on health and social care services.

Equalities Challenges

The **2020/21** report focused on equalities challenges and learning from COVID, which recognised the impact of COVID-19 and impact of housing, and the indirect impact on employment with out of work benefits increased, increase of support levels.

And the key messages remain. We need to: better understand the different needs of our communities; continue to develop the role of council and partners in reducing health inequalities; create more opportunity for resident engagement and involvement particularly with underserved, vulnerable and marginalised groups; focus on best start in life, including reducing family poverty and access to mental health services, education and training for young people, increase diagnosis and early intervention; address social determinants of health to remove barriers to health and develop the use of social prescribing.

People, Partnerships and Place

In 2021/22 I reported on the development of the Place-based Partnership, the publication of the best start in life strategic framework, with a particular focus on supporting parents to improve development and school readiness, and the actions needed to address inequalities using the Marmot principles within the population intervention triangle which remains the model of place-based working.

2023

So, to 2023 - this report takes the issues laid out over the last 10 years further, with a particular focus on improving healthy life expectancy, looking at how:

- The Partnership through the development of placed based working (localities)
  - creates a shared understanding of health outcomes based on data and evidence of need to develop community civic and services-based interventions (the population intervention triangle (see Figure 3)
  - can lead the coordination of more accessible and engaged services using the POTS framework (see Figure 4)
  - can take a systematic approach to early identification and treatment of health conditions causing greatest problems to individuals' communities and care system
  - creates opportunities for pooling budgets
- An in-depth review of services for 0-5- and 5–19-year-olds can help us re-procure the 0-19 healthy child programme services to meet the agreed Joint Local Health and Wellbeing Strategy 2023-28 shared outcomes and developing healthy building blocks for the future.
- We need to develop the current lifestyles services to meet the differing needs of the population and produce population health outcomes, based on what good looks like.
- We can meet the level of investment needed to protect the population from communicable disease threats and meeting the new health protection responsibilities of the council, learning from COVID-19.

Chapter 2:
Exploiting Opportunities to Improve Health

Key facts

Residents are around three times more likely to suffer an avoidable death than people living in the 10 least deprived areas of England[2].

Adults in Barking and Dagenham are more likely to have a long-term health condition than their counterparts in other areas, with the borough having the highest prevalence of four of the 'Top 10' health conditions (heart disease, chronic obstructive pulmonary disease, lung cancer and stroke).

Many residents suffer unrecognised and therefore unmanaged long-term conditions, with around 38,000 estimated undiagnosed cases of the six most common long-term conditions. Approximately 1 in 3 people have at least 1 long term condition and 1 in 6 people have 2 or more long term conditions.[3]

In 2022/23 there were 790 school reception children in Barking and Dagenham measured as overweight or obese (24%) which was the highest in London.

This report is focusing what we can do in the short term (during the next 5 years) to improve the health of the population, to increase the number of years our residents spend in good health and able to live independently for longer.

The recently published annual report of the Chief Medical Officer highlights the importance of improving the quality of life of older people by tackling conditions – both medical and environmental - which impact on their ability to live independently and in good health. Even though he was particularly highlighting issues in areas where there is often a higher population of older people than in Barking and Dagenham – the issues remain important to our residents as:

- Black ethnicities develop a long-term health condition over five years earlier than their White neighbours (see Table 3),
- have high demand for support services.
- high levels of unhealthy behaviours and
- are more impacted by the cost-of-living crisis which puts them at higher risk of poor health.

Therefore, the report's recommendations are useful to take into our current planning discussions:

a) **Services to prevent or treat disease and provide infrastructure** need to be planned, including support services e.g. housing.

b) **Develop the environmental infrastructure** which can delay or prevent the chances of early ageing (primary prevention), for example making it easy and attractive for people to exercise throughout their lives; reducing smoking, air pollution and exposure to environments that promote obesity.

c) **Delaying disease to the greatest possible extent**, to delay the period of disability in older age - the longer people live with risk factors such as hypertension or high cholesterol, the earlier the start of their disabilities will be. Screening programmes help to delay or stop the onset of serious disease and therefore prevent ill health in later life. It is essential that we prioritise secondary prevention and screening services and do more to extend these services to groups with reduced access and historically low uptake.

d) The medical profession needs to **respond to the rise of multiple long term conditions.** NHS organisations also need to minimise the probability that the same person must attend multiple clinics for a predictable cluster of diseases.

I therefore advise **we need to consider** introducing shared outcomes aligned to reducing the gap in both female and male healthy life expectancy, focused on:

1. Preventing and managing long term conditions, ensuring early diagnosis and pathways are clear to support early intervention.
2. Reducing obesity and smoking through targeting services to those who need is greatest as well as developing wider system working (see Figure 4).
3. Improving the number of children achieving a good level of development by five.

To set this in context this chapter provides an overview of the key health needs of our residents; particularly focusing on improving our healthy life expectancy outcomes and the need for us to tackle the large health differences experienced by our residents; the need to level up of resources across the NHS North East London (NHS NEL) footprint based on the significant unmet need there is within our population recently reported and acknowledged by NHS NEL, including the opportunities we have to address these through our current agreed strategic direction; leadership to deliver outcomes through joint delivery plans, our place-based working and how we decide to invest our collective resources.

Strategic Plans and Agreed Outcomes

The recently published Joint Local Health and Well Being Strategy, which aligns with the councils Corporate Plan and NHS North East London Joint Forward Plan provide us foci for our direction of travel including the desire to address the differences in health experienced by different communities – what our data shows is that some residents die earlier than we would expect against the national average and too many of our residents live longer in poorer health than others. This is unacceptable and despite many commitments across partner organisations this situation has not changed over the last 10 years.

It is however difficult to assume a cause-and-effect relationship between what has been done and these outcomes as we have seen the 3rd highest increase in London in ten years (17.7%), and the highest raise (26.1%) in our residents under-16 years old the young population, bringing families with more complex needs and ethnic diversity as Barking and Dagenham is seen as a more affordable borough to its counterparts in inner London with excellent transport links into central London.

But we must not be disheartened and remain committed to addressing these differences and meet the vision of our Joint Local Health and Wellbeing Strategy for our residents to have improved physical and mental health and wellbeing, with a reduction in the gap in health inequalities between Barking and Dagenham residents and people living elsewhere.

Outcomes

The vision of the Joint Local Health & Wellbeing Strategy 2023-28 (JLHWS) has been translated into shared outcomes for overall improvement in life expectancy and healthy life expectancy (I return to this later in this chapter).

The following long-term outcomes have been agreed:

Best Start in Life

We want babies, children, and young people in the borough to:

- Get the best start, be healthy, be happy and achieve
- Thrive in inclusive schools, settings and communities
- Be safe and secure, free from neglect, harm, and exploitation
- Grow up to be successful young adults

Living Well

We want to ensure residents live well and realise their potential, and when they need help, they can access the right support, at the right time in a way that works for them.

Ageing Well

We want residents to live healthily for longer and:

- Be able to manage their health, including health behaviours, recognising and acting on symptoms and managing any long-term conditions.
- 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.
- Their health and wellbeing are improved to support better opportunities (educational, employment, social) and independent living for as long as possible.
- Achievements of these outcomes will take time and shorter actions are needed. I return to this later in this chapter.

Our Priorities Over the Next Five Years

Ensuring good health and wellbeing and preventing the need for expensive health and social care is crucial in this financial climate, with funding pressures for all our system partners. We must therefore prioritise; focusing on impacts over the next five years on those interventions which will improve healthy life expectancy and address health inequalities which will also help us meet the wider priorities of the council for example good quality employment doesn't only enable good health, good health also is important to maintain economic activity.

As a report from ONS[2] identified; the number of people economically inactive because of long-term sickness has risen to over 2.5 million people, an increase of over 400,000 since the start of COVID-19. And for those economically inactive because of long-term sickness, nearly two-fifths (38%) reported having five or more health conditions (up from 34% in 2019), suggesting that many have interlinked and complex health issues.

A recent report[3] revealed that nearly 460,000 people in the UK are unemployed due to the consequences of health-harming products, resulting in a loss of £31.1bn from the economy. The analysis shows that 289,000 people are not working due to poor health caused by smoking, while 99,000 are unemployed because of illness caused by alcohol, and 70,000 are unemployed because of weight-related health conditions.

The following priorities have been agreed within the JLHWS; but we need to focus our attention on actions which will make the biggest difference in healthy life expectancy over the next five years, and therefore are suggesting we focus on the top three, but recognising there will be elements of the last three reflected in delivery plans.

The Joint Strategic Needs Assessment 2023 has been complemented by other important sources (such as the 2021 Census) to create a set of key priorities agreed by the Place-Based Partnership and set out in the Joint Local Health and Wellbeing Strategy 2023-28.

These are:

- Improving outcomes for people with long term conditions in children and adults.
- Addressing unhealthy weight and smoking in children and adults.
- Providing the best start in life for our babies, children, and young people.
- Preventing and addressing domestic abuse.
- Preventing exposure to and the consequences of adverse childhood experiences.
- Addressing wider determinants of health- for example unemployment, poor housing, low level of training, education and skills development.

Measuring Impact

It will be important that the Place-based Partnership decides on the measures it wants to reach against its agreed outcomes, based on realistic timescales (see Figure 2). For example, the Health Foundation reports that it can take up to 10 years to see a difference in health inequalities[4] and a review of the impact of the comprehensive programme to reduce health inequalities in England implemented by the UK government between 1997 and 2010. Health inequalities Strategy[5] suggested improvements in inequalities in life expectancy between more and least deprived areas could be seen within three years, which is likely to have been related to the targeted action (although this cannot be proved with the analysis[6].)

This would be underpinned by the actions we are taking to address health inequalities and work is currently underway to identify and agree using targets to better support health inequalities reduction, and we will use the key recommendations from the Health Foundation to do this, which include:

- Focus on improving the health of the most disadvantaged groups and geographic areas (e.g. the 20% most deprived areas***, children and minority ethnic groups).
- Taking a long-term viewpoint, as it takes around 10 years to achieve measurable reductions in health inequalities.
- Focus on ambitious, but achievable targets using both a range of long-term health indicators (e.g. infant mortality rates, life expectancy, healthy life expectancy, prevalence of overweight and obesity in adults and children, prevalence of anxiety and depression in adults, and suicide rates) and interim indicators of social and behavioural determinants of health (e.g. household relative poverty rates, employment rates, relative child poverty rates, educational attainment rates, physical activity, diet).

We also need to consider the existing Borough Manifesto targets:

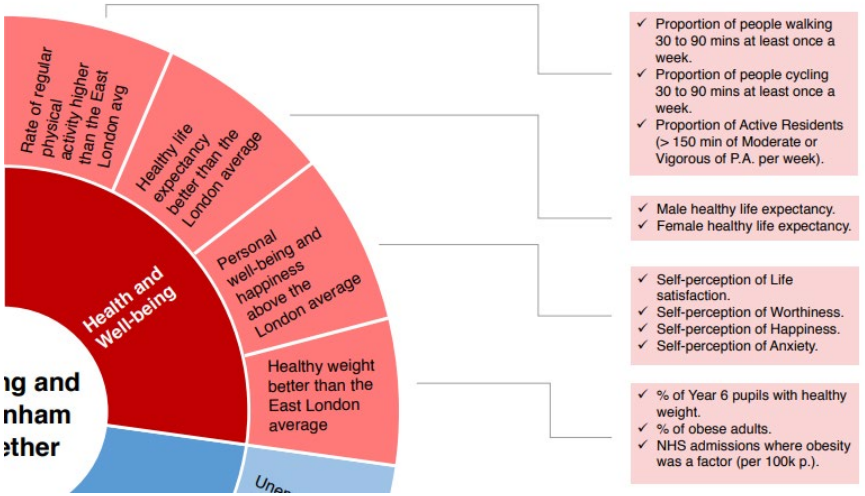


Figure 1: Barking and Dagenhams' Borough Manifesto health and wellbeing targets

*** all but 3 of our wards are in 20% most deprived by Index of Multiple Deprivation nationally, which means there is a need for hyper-localised approaches to target the communities most in need

Delivery Plans

Actions to deliver our agreed priorities have different development times (see Figure 2) which would need to be considered in any overall delivery plan, particularly if we want to see impacts over the next 5 years. A logic model can be a useful tool to provide an overview of the different interventions which will have incremental impacts to achieve our agreed outcomes.

This figure shows which actions will have impact in the short term, benefiting high service demands. But we should not forget the importance of the longer-term benefits of interventions within A and B, which must run alongside any actions benefiting the short term. They also coexist and often people need support to deal with many social determinants of health for example impacts of the cost-of-living crisis before they can consider health behaviour choices.

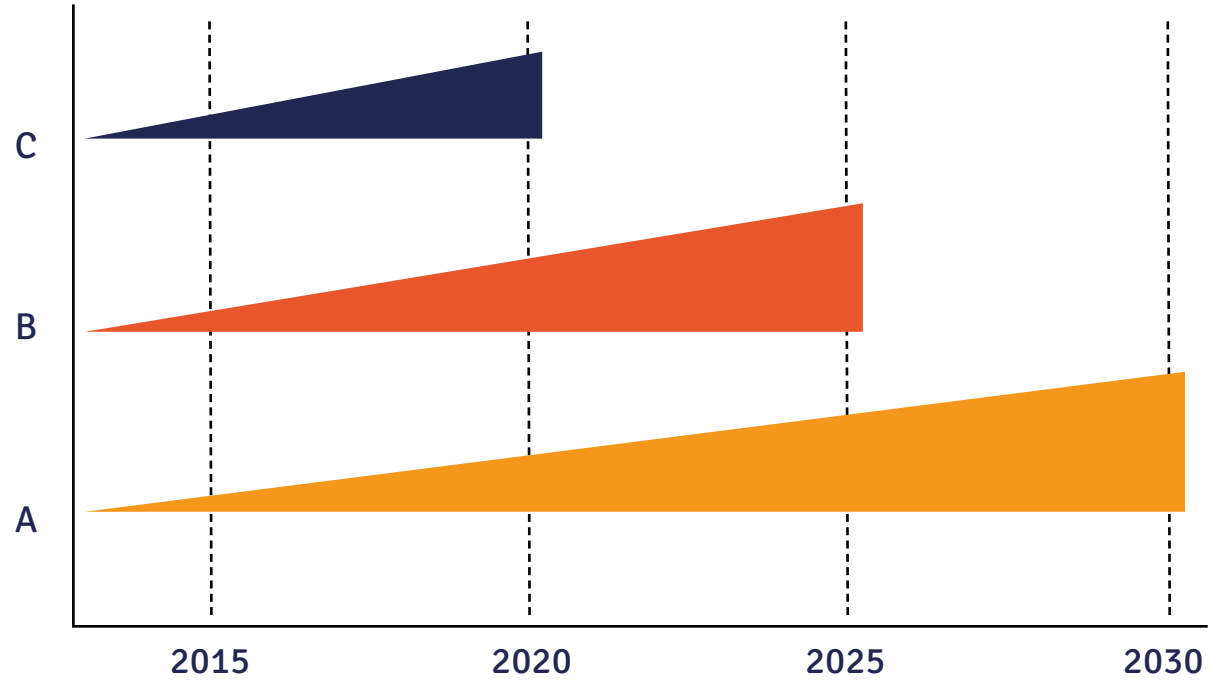


Figure 2: Time needed to deliver outcomes from different intervention types[7]

Place Based Working

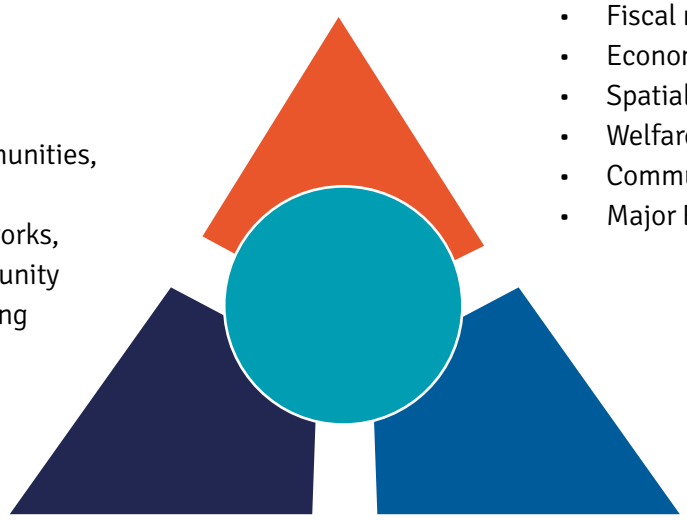
Effective delivery will only happen if **place-based action** is framed within the Population Intervention Triangle - which requires robust governance with clear leadership and evidence - based delivery plans setting out responsibilities across all partner organisations, that have been coproduced with residents.

Working in localities is a key delivery model for this way of working.

Civic-level Interventions

- Legislation; regulation; licencing; by-laws
- Fiscal measures: incentives; disincentives
- Economic development and job creation
- Spatial and environmental planning
- Welfare and social care
- Communication; information; campaigns
- Major Employer

- The assets within communities, such as the skills and knowledge, social networks, local groups and community organisations, as building blocks for good health.



- Delivering intervention systematically with consistent quality and scaled to benefit enough people.
- Reduce unwarranted variation in service quality and delivery
- Reduce unwarranted variability in the way the population uses services and is supported to do so.

Community-based Interventions

Sevice-based Interventions

Figure 3: The Population Intervention Triangle

Developing Place-Based Working – The Role of Localities

At the forefront of action is a genuine commitment to the value of relationships and coproduction with residents in designing or discovering changes to meet the needs of our communities

Joint Local Health & Wellbeing Strategy 2023-28

Three of the key principles underpin delivery – coproduction with communities, Integrated Care and taking place based action are central to the development of an effective model to deliver services and develop healthy places which address health inequalities and improve healthy life expectancy.

My reports in 2016/17 and 2018/19 describe an evolving locality model in Barking and Dagenham, which enables a place-based response to improve the health and wellbeing of our residents and reduce service demands. The following principles reported then, remain relevant today:

- The locality model provides health improvement, and health and social care for a defined population, usually (50,000 – 70,000 people) and will involve developing different strategies for different segments of the populations that they serve, depending on needs and levels of health risk.
- The starting point to establish place-based systems of care is to define the population served and what the barriers to, and boundaries of, collective working are. The scope should not just be focused on the NHS and social care but also on the wide range of other council services and other partners that contribute to health, such as the Metropolitan Police, London Fire Brigade, schools, and the voluntary community sector. This provides the opportunity to focus on the wider health and social care needs of the population that they serve.

- Within the locality model there will need to be a neighbourhood level. This is primarily to address inequalities by delivering a range of interventions aimed at improving the health of individuals within the small geographical areas (such as deprived estates). These interventions are many and varied and involve input from several organisations and services.
- Central to this is the place-based care model, which encourages providers of services to work together to improve the health and care of their population around a shared vision and shared objectives, using pooled budgets to deliver services that work together.
- We can build upon our Integrated Care Model that works in our existing localities, which includes co-located health and social care teams. We need to build on this existing good practice with a clear focus on population-level outcomes and shared decision-making processes to assess how best to get there.

Since my last report, the Fuller report was published- this recognises the essential role primary care (including community pharmacy, dentistry, optometry, and audiology) must play working in partnership to prevent ill health, tackle health inequalities and manage long-term conditions.

This vision is key to an integrated locality model which aims to deliver prevention and early intervention tailored to the needs of the local community; providing choice about how they access care; proactive personalised care supported by multidisciplinary teams and action to help people stay well for longer.

This approach and a recognition of the broader role of primary care, provides an excellent opportunity to tie this workforce into the wider localities model we are currently leading (described below), particularly when looking at our approach to preventing, and managing long term conditions.

This reorientation of the workforce will also enable us to support our most vulnerable residents and those with complex needs to stay at home and access care in the community which will, over time, contribute significantly to efforts to reduce growth in hospital demand.

Locality Working

The development of locality working at Place is an iterative process comprised of several stages. The experience of those who are further ahead suggests it is important that places invest in the process of developing locality ways of working, approaching engagement in this as a meaningful way of furthering integrated working arrangements, and recognising that there is the likelihood of further iteration and evolution of the model over time.

This is where the shared outcomes outlined in our Joint Local Health & Wellbeing Strategy 2023-28 are a powerful mechanism for making integrated services a reality. From there, our partners set out how the priorities will be delivered, and the measurables used to monitor progress. A locality focused delivery plan may map out how organisations and services will collectively deliver the priorities.

Shared outcomes support integration at place level and are key in connecting our partners plans and strategies into coherent and focused delivery plans for meeting those outcomes. For me, the key benefit will be to address current complexity of service planning that by design has developed 'systems within systems' to focus on various aspects of performance, transformation, and access across the life course, drawing on skills and services from across the partnership. The challenge to new 'ways of working' going forward is to ensure that the services we deliver forms part of a coherent, mutually reinforcing approach, rather than becoming a disjointed set of initiatives. And puts residents in the heart of decision making to improve accessibility and acceptability of services and programmes to improve health.

This approach also provides the opportunity to deliver an evidenced base approach to tackle health inequalities. As discussed earlier this chapter, achieving a reduction in population health inequalities requires a long-term, place-based approach across three types of interventions (i.e. the Population Intervention Triangle): Civic-level interventions (e.g. licensing, economic development); Community-based interventions (e.g. using and building assets within communities); and Services-based interventions (e.g. quality and scale, reducing variation).

But more specifically to address factors which are driving our poor healthy life expectancy and related health inequalities I advise that the Barking and Dagenham Place-based Partnership use the Population Outcomes through Services (POTS) (Figure 4) evidence-based framework to determine which interventions to develop and apply the following criteria needs to ensure these interventions are effective:

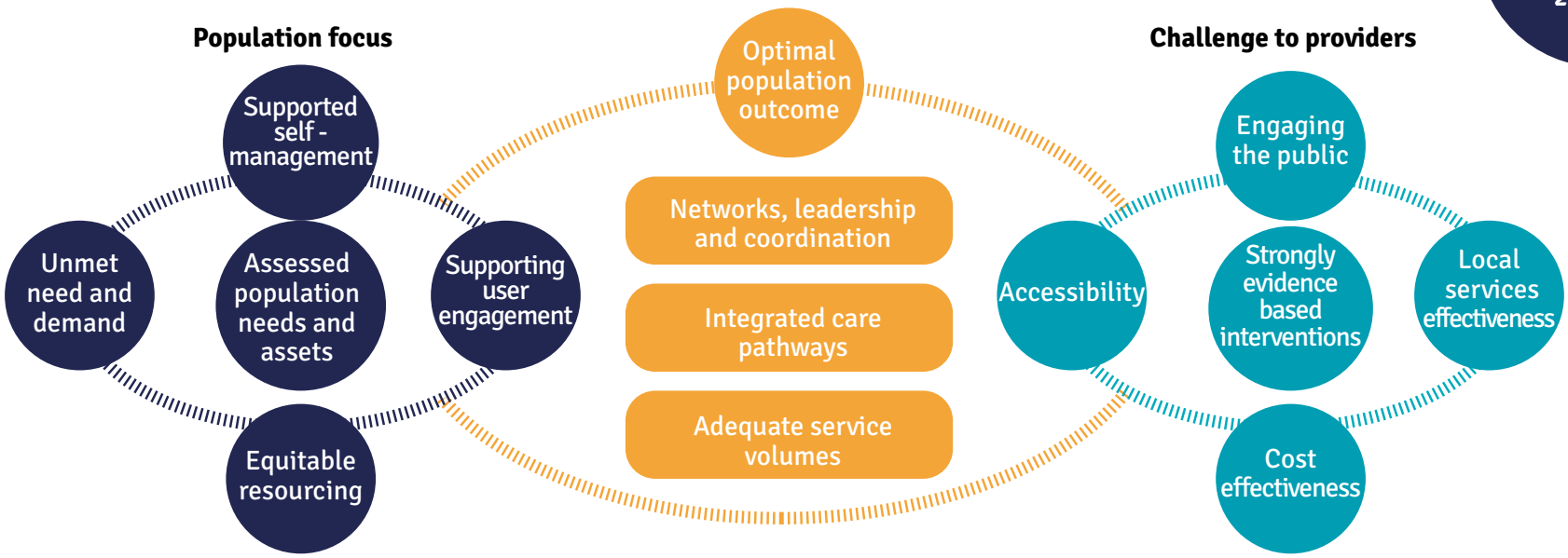


Figure 4: The population outcomes through services (POTS) framework[68]

Localities network case study

In the first year of the health inequalities programme, invested in community sector infrastructure to improve health at a population level through creating networks of civil society organisations working with residents to re-define local problems and solutions related to health inequalities and the cost-of-living crisis, alongside statutory sector partners building on the lessons of the BD CAN partnership during the pandemic.

Community Locality Leads were established and have operated over the last year borough-wide across six areas, roughly the same geographies as the Primary Care Networks, across the borough's three localities. The Leads are voluntary sector organisations that provide local connections in communities; triage support for residents; build a connected network of community partners and working with residents to design prototypes to meet cost-of-living and health inequality challenges as identified by residents.

Through their triage process, Community Locality Leads have held around 2,600 conversations with residents, which informs their approaches, as does the mapping of 'connecting places' such as civil society organisations, social spaces and natural points of connection, with an estimated 500+ such places in each locality. Community-led design has ranged from collaboration with statutory sector partners to bring health services into the community and improve access for marginalised groups, such as pop-up clinics for those who are homeless, to small-scale community groups like choirs.

To date, the approach has enabled shared learning between the voluntary sector, NHS and council partners and a shift in statutory partners' understanding of the value of the voluntary sector and the relationships they hold with residents.

Following this 'proof of concept', is currently being reviewed which will complete in early 2024 with the revised approach planned for Summer 2024 onwards.

Investing to Improve Health

Although there is a strong and steadily growing evidence base that prevention is a cost-effective way to reduce demand on the NHS and social care services, our existing prevention programmes and services are yet to provide these benefits, as achieved in other parts of London and the country. We will miss a trick if we don't capitalise on this opportunity to jointly plan, invest, and deliver integrated prevention programmes that go beyond care to address our agreed outcomes and priorities.

It is also important to acknowledge that reducing demand and prevention are not the same thing. A key long-term outcome of prevention would be a reduction in the use of high-cost downstream services, such as emergency departments, adult social care and care homes and prevention programmes are part of the solution.

The Place based Partnership has made a strategic commitment to improve the health of the residents of Barking and Dagenham. Therefore, core funding and activities must be jointly considered to deliver agreed plans against our priorities. The funding provided by the Public Health Grant (PHG) can add value to this mainstream activity and funding. Over time formal joint funding arrangements could be considered, learning from our experience with the existing Better Care Fund which is a joint budget between the NHS and the council with a focus on prevention.

Firstly however, I need to consider whether the PHG is being invested in the right services/interventions which impact on our shared public health outcomes as detailed in our Joint Local Health and Wellbeing Strategy 2023-28. As well as the required balance of the PHG allocation to deliver both population health management as well the shared public health outcomes.

The allocation has remained mostly unchanged since 2016 and now is an opportunity for this to be reviewed in line with the borough's changing demography and need. This section provides an overview of how the grant was spent in 2022/23 and changes to responsibilities and accountability for delivery of value for money and outcomes for public health programmes and services linked to assurance statements.

The Health and Care Act 2012 transferred public health responsibilities to local authorities by way of a ring-fenced PHG received from national government to:

- Significantly improve the health and wellbeing of local populations.
- Carry out health protection functions delegated from the Secretary of State.
- Reduce health inequalities across the life course, including within hard-to-reach groups.
- Ensure the provision of population healthcare advice.

Local authorities are mandated, through the grant to fund a range of public health activities including sexual health services, sexually transmitted infections testing and treatment and contraception; NHS Health Check programme; health protection; public health advice to commissioners; the National Child Measurement Programme and mandated children's 0-5 services and health visiting.

It is planned that from 2023 end of year returns, categories for reporting local authority public health spend will be split into prescribed and non-prescribed functions[8].

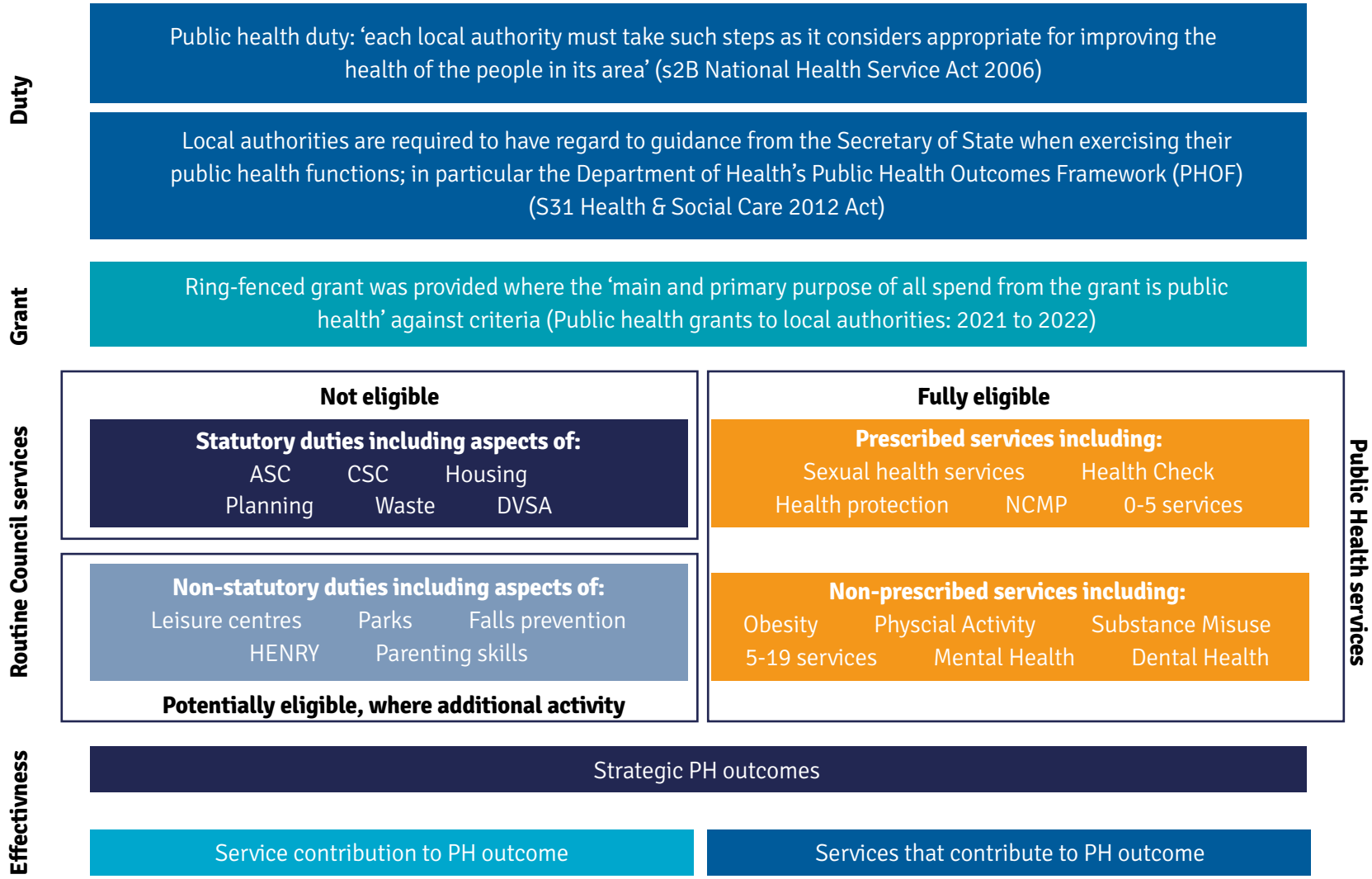


Figure 5: The public health duty for local authorities

For financial year 2022/23, the council received a PHG allocation of £17,787,080.

The grant allocation is mainly as below, going forward, the allocations will be reviewed to see if they are still the right thing to commission from next year, to meet our priorities.

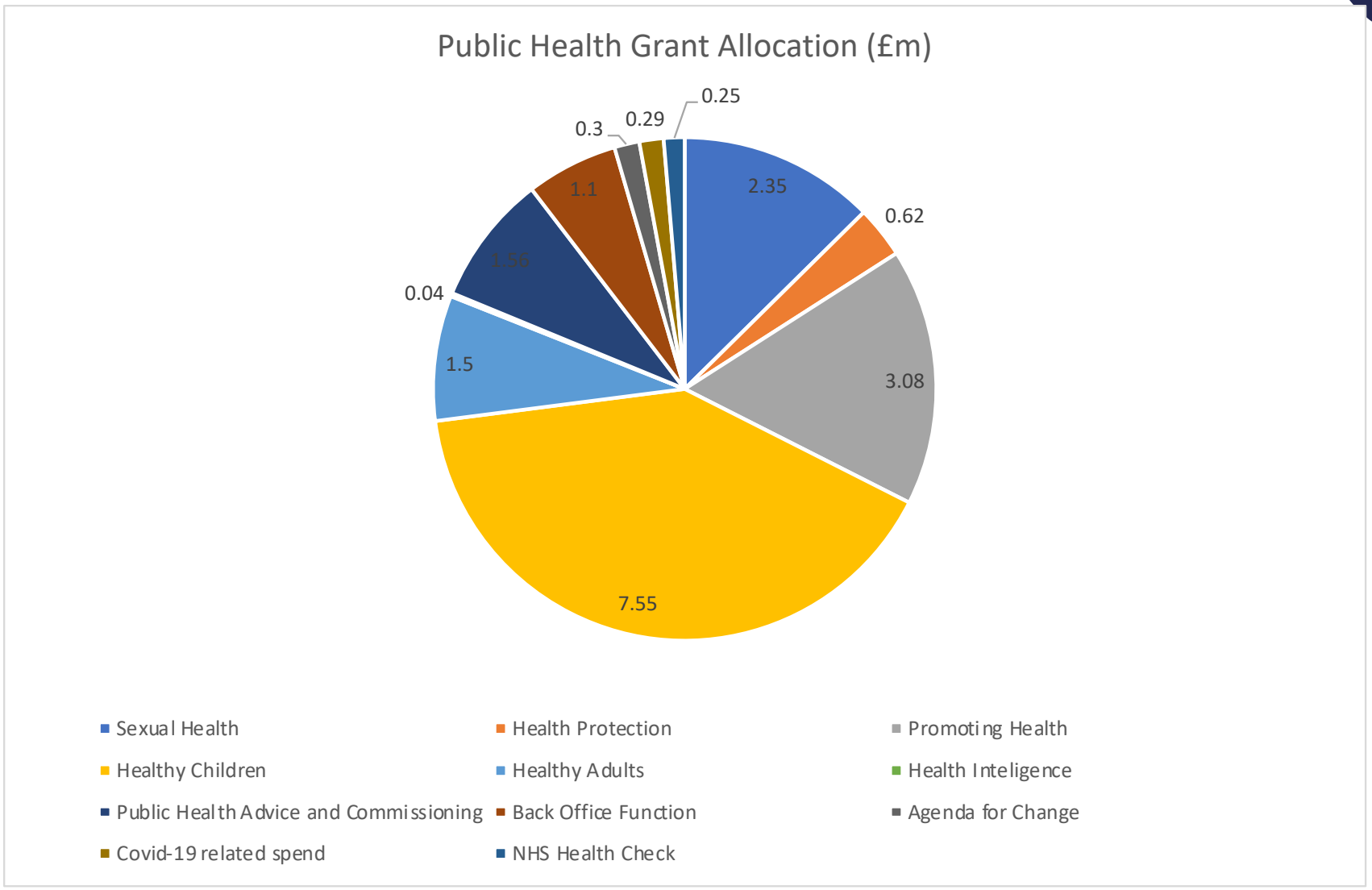


Figure 6: Breakdown of spend for the Barking and Dagenham Public Health Grant in 2022/23

The PHG spend is monitored by a public health programmes board chaired by the Director of Public Health.

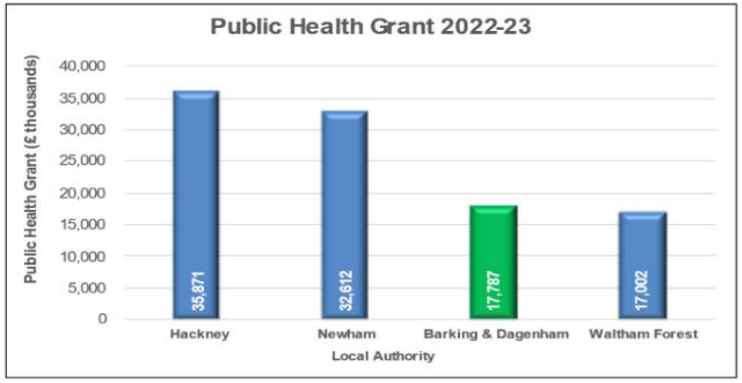
Figure 7 below gives an overview of the grant allocation compared to other north east London borough neighbours that are similar in socioeconomic profile. This reflects that the PHG received does not meet the needs in the borough as the allocation per head is 3rd lowest of the boroughs, despite having one of the highest needs.

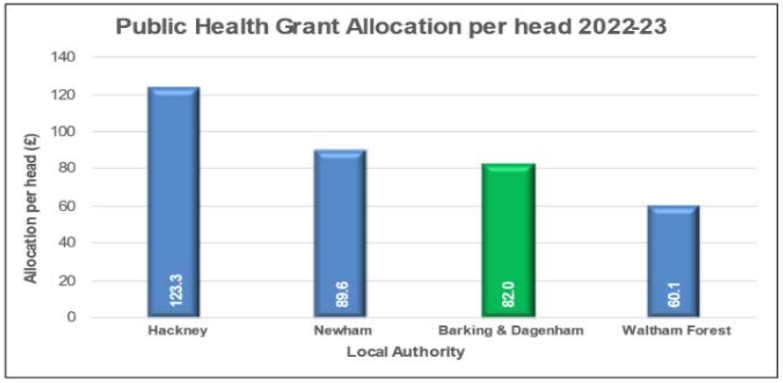
Benchmarking of Cost Drivers

Public Health grant allocations for 2022-23

Local Authority	Public Health Grant (£ thousands)	Allocation per head (£)	2022 projected population
Hackney	35,871	123.3	290,891
Newham	32,612	89.6	364,021
Barking & Dagenham	**17,787**	**82.0**	**216,826**
Waltham Forest	17,002	60.1	283,108

Barking and Dagenham is compared to NEL neighbours who are also CIPFA nearest neighbours (matched on socioeconomic profile). CIPFA does not take into account ethnicity, but NEL boroughs will have similar ethnic profiles.





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Source: Public Health local authority allocations 2022 -23

Figure 7: Public health grant allocations for similar north east London boroughs 2022-23

This is demonstrated when we look at performance across key public health outcomes (see Table 1); we are among the worst nationally for healthy life expectancy, obesity, school readiness, and some sexual health and immunisations outcomes. Whilst this is associated with our local deprivation; when we compare ourselves to Newham, a local neighbour with similar socioeconomic need and public health allocation per head, we are worse in relation to healthy life expectancy, obesity and school readiness outcomes.

Key Performance Indicators

Source: Public Health Outcomes Framework

Barking & Dagenham

Category	Outcome Indicators (indicative sample, not all represented)	National performance	LBBD performance	Newham performance	Period	LBBD National Benchmarking Summary
Overarching	Life Expectancy M F	M 79.4 F 83.1	**M 77.0 F 81.7**	M 79.0 F 83.1	2018-20	worst/lowest to 25th percentile
	Healthy Life expectancy at birth M F	M 63.1 F 63.9	**M 58.1 F 60.1**	M 59.5 F 64.6	2018-20	worst/lowest to 25th percentile
	Cumulative percentage of people who received a healthcheckage 40-74	27.4%	**46.5%**	100% (data quality issue)	2018/19-22/23	75th percentile to best/highest
Child Health	Low birth weight of term babies	2.8%	**3.8%**	5.0%	2021	worst/lowest to 25th percentile, no significant change
	Hospital admissions caused by unintentional and deliberate injuries in childrenage 0-14 crude rate/1000	84.3	**52.3**	58.2	2021/22	75th percentile to best/highest
	% of school children achieving a good level of development at reception	81.1%	**62.5%**	68.7%	2021/22	worst/lowest to 25th percentile
Sexual Health	New STI diagnoses (excluding chlamydia aged under 25) per 100,000'	496	**599**	990	2022	worst/lowest to 25th percentile
	Under 18 Conception Rate/1000	13.1	**12.5**	9.9	2021	25th percentile to 75th percentile
Substance Misuse	Admissions episodes for alcohol (persons) (per 100,000)	494	**354**	352	2021/22	75th percentile to best/highest
	Deaths from Drug misuse (per 100,000)	5.0	**3.0**	2.6	2018 - 20	75th percentile to best/highest
Health Protection	Population vaccination coverage : MMR (5yrs old)	1 dose 93.4% 2 doses 85.7%	**1 dose 86.4%** **2 doses 67.8%**	1 dose 84.9% 2 doses 69.9%	2021/22	worst/lowest to 25th percentile, worsening
	Cancer Screening coverage: bowel cancer	70.3%	**57.4%**	55.4%	2022	worst/lowest to 25th percentile, improving
Tobacco	% smoking prevalence in adults (18+)- current smokers (APS)	13.0%	**11.3%**	13.9%	2021	25th percentile to 75th percentile
Obesity/ Physical Activity	% overweight/obese at reception	22.3%	**27.5%**	22.7%	2021/22	worst/lowest to 25th percentile, no significant change
	% overweight/obese at yr6	37.8%	**49.1%**	46.3%	2021/22	worst/lowest to 25th percentile, worsening
	% overweight/obese at adult	63.8%	**70.5%**	47.3%	2021/22	worst/lowest to 25th percentile
	% physically active adults	67.3%	**58.4%**	63.9%	2021/22	worst/lowest to 25th percentile
Mental Health	Self reported wellbeing: % with a low satisfaction score	5.0%	**2.8%**	low count	2021/22	75th percentile to best/highest
	Emergency hospital admissions for intentionalself harm (per 100,000)	163.9	**69.6**	52.1	2021/22	75th percentile to best/highest

Table 1: Public health outcomes for Barking and Dagenham compared with national averages and Newham's performance

The Future Direction of the Public Health Grant

We are proposing to transform public health programmes from 2024/25; partially through the development of partnership plans to delivery our priorities, but also through changes to the PHG allocation and services commissioned and delivered against public health outcomes, which recognises the commitment of all partners to meet the priorities set out in the Joint Local Health & Wellbeing Strategy 2023-28.

Therefore, the PHG needs to be directed towards those factors which the evidence suggests will improve health life expectancy (which I describe in chapter 3) i.e. addressing long term conditions and risk factors for poor health – smoking and obesity, focusing on the underpinning health inequalities within in these contributory factors. To address these issues, there are several building blocks for health which are needed, including best start for life, in particular school readiness, health literacy, community cohesion, unemployment and improving mental health and wellbeing that need to be addressed (see Figure 8).

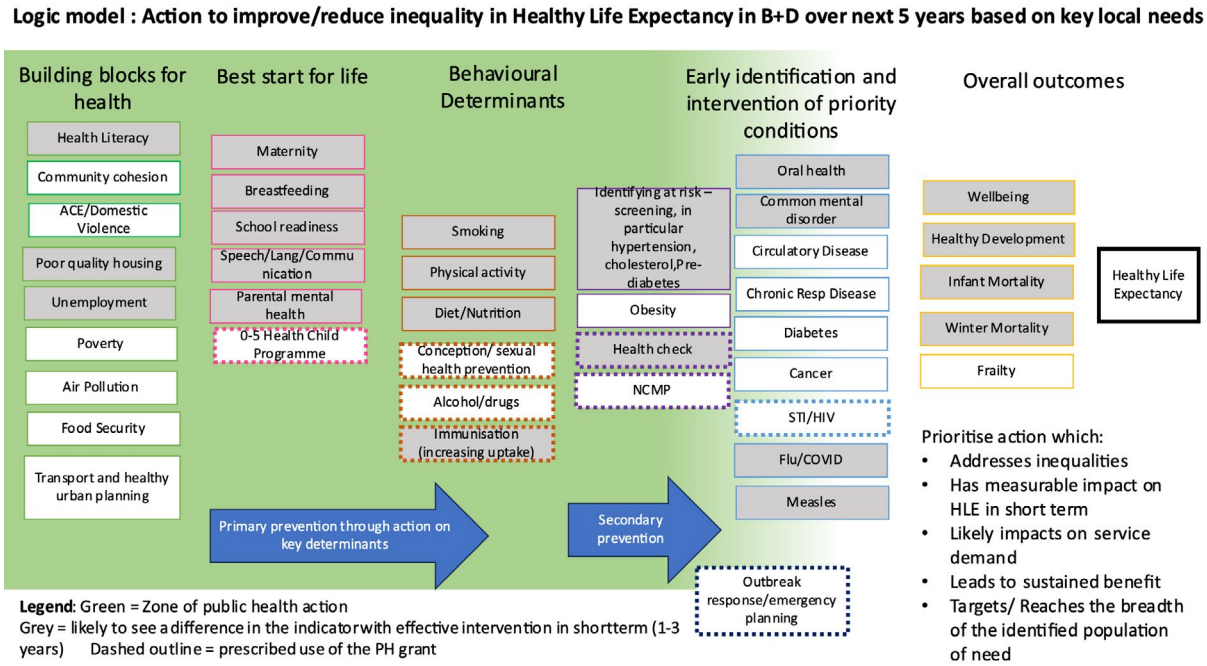


Figure 8: Action to improve/reduce inequality in healthy life expectancy in Barking and Dagenham over 5 years

Public Health Advice

We need to exploit the opportunities we have in the Place based Partnership to improve female and male healthy life expectancy by:

- Agreeing shared outcomes and priorities.
- Aligning strategic plans, develop agreed delivery plans and outcomes of the locality model.
- Invest together on programmes to deliver our priorities and reprioritise our spending of the Public Health Grant.

Chapter 3:
Why is healthy life expectancy key to improving health and managing health and social care demand?

Measuring Impact

Although increasing life expectancy, particularly the inequalities we see in Barking and Dagenham is important (see JSNA, 2022), I suggest in this report that we focus on increasing healthy life expectancy and addressing those contributing factors which in the short term, impact on overall health, ability to live independently in later life, and on the increasing demand on our health and care system. If an approach is well structured, actions identified can provide results within the five years of the Joint Local Health & Wellbeing Strategy 2023-28 (JLHWS).

Healthy Life Expectancy

Healthy life expectancy (HLE) describes the average number of years a baby born today would expect to live in good health. It is based on data combining risk of death and people's self-reported good health. Analysis of why we have lower healthy life expectancy can also help us develop a plan to reduce the impact on the rising demands on social care and health services. It is often measured through 'Disability Adjusted Life Years'. This is a measure of the number of healthy years of life lost from disease and ill-health.

Nationally there has been little change in HLE between 2014-16 and 2017-19 because improvements in health in older people have been balanced by worsening health in the younger population. The cost-of-living crisis has put additional strain on the wider determinants of health. It is therefore important to focus on efforts to improve HLE across the life-course, as our JLHWS identifies starting well, living well and ageing well, even if the impacts on children and young people take years to realise.

Our Borough Manifesto in 2017 set out targets to achieve a better healthy life expectancy than the London Average by 2037 (14th out of all London Boroughs). However, recent, and ongoing challenges mean we have seen little improvement in recent years – and this is true both of London and nationally.

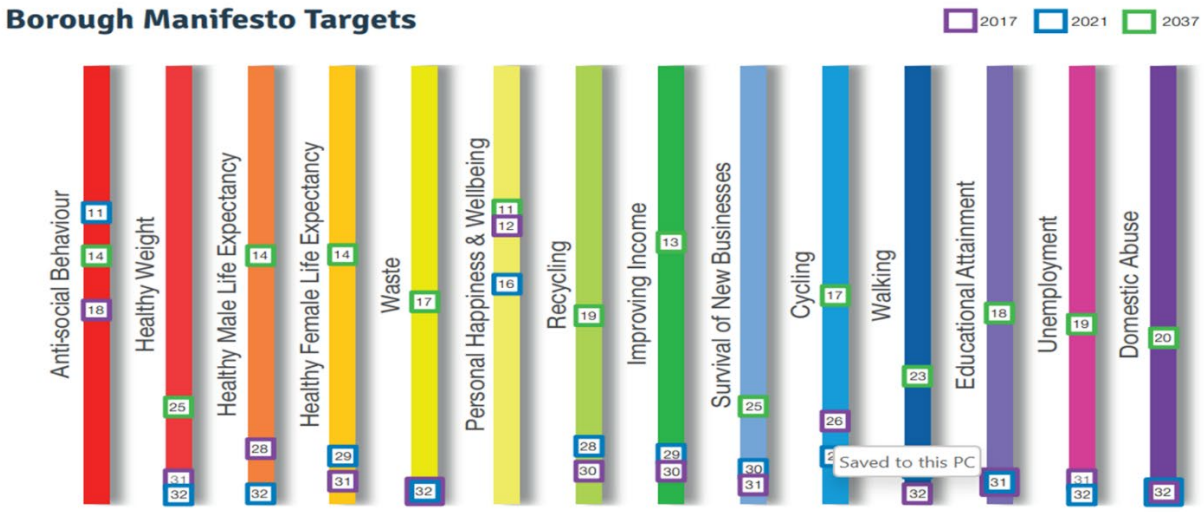


Figure 9: The Borough Manifesto targets for 2017-2037

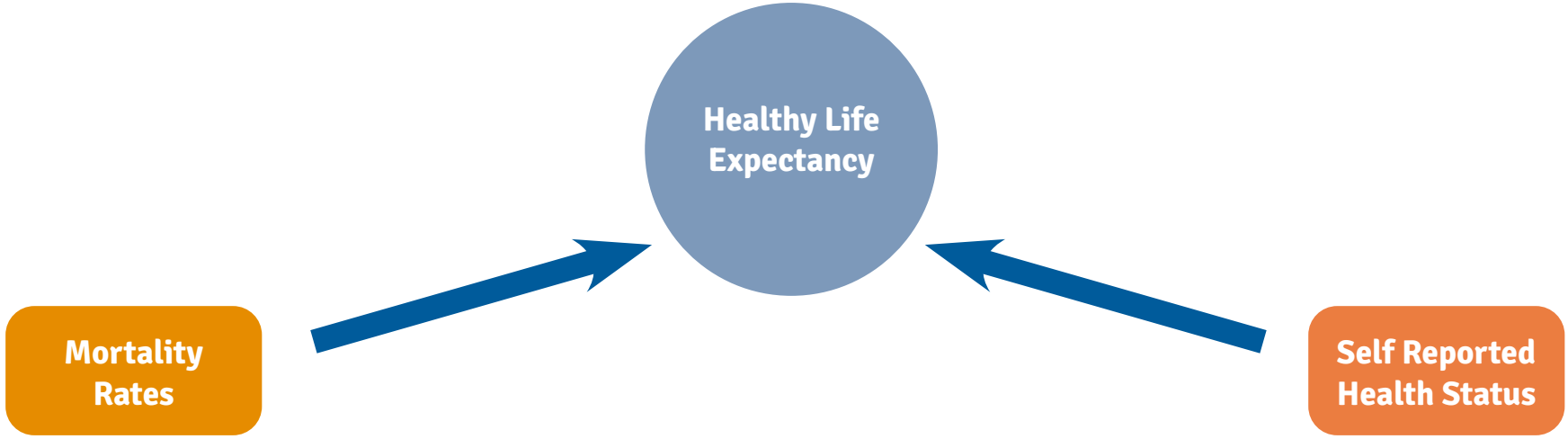


Figure 10: The relationship of self-reported health status, mortality rates and healthy life expectancy[9]

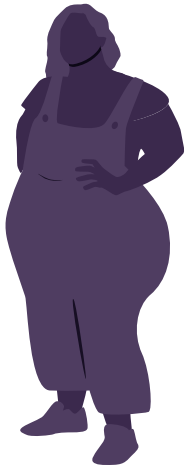
Male healthy life expectancy is 58.1 years in Barking and Dagenham, which is lower than the England average of 63.1 years (in 2018-20) and has been significantly lower most years during the last decade.

Female healthy life expectancy is 60.1 years, this is also significantly lower than the England average of 63.9 years for England (in 2018-20), and again has been for most years during the last decade, although improvements have been seen since 2012-2014 when healthy life expectancy for women in Barking and Dagenham was only 53.6 years.

Self-reported Health

National analysis[10] shows an increase in self-reported good health has a greater impact on healthy life expectancy compared to a decrease in mortality rates, although it should be noted that factors linked with poorer mortality and self-reported health status are complex, overlapping, and likely to interact with one another.

In addition to the strength of association between the health condition and self-reported poor health, the prevalence of the condition will also be important in determining its overall influence on population-level healthy life expectancy.



For example, a 2% improvement in mortality rates would improve healthy life expectancy by 0.1 years, compared to a 2% increase in self-reported good health that would improve healthy life expectancy by 1.3 years.

What Are the Main Contributors to Self-Reported Ill Health?

Research shows that the most consistent and strongest links with self-reported poor health are **chronic health conditions and multiple long term conditions**. In almost all studies, having a chronic condition significantly increased the chances of self-reported poor health. There was also strong evidence that a cumulative effect of having multiple chronic conditions increased the odds of self-reporting poor health further.

National data and wider research suggest the following are linked with worse self-reported good health.[11],[12], Data below shows that our residents are affected by all contributors.

Ill health:

- Having a long-term condition: 29.1% of GP registered patients have one or more long-term condition in Barking and Dagenham[13] (there are more registered patients than those living in the borough, as some patients do not always re-register when they move).
- Having multiple long term conditions (has a cumulative effect): 13.4 % of GP registered patients have 2 or more long term conditions[14].
- Muscular Skeletal Conditions are one of the top three conditions which impact on numbers of healthy years lost. [15]

Risk factors for ill health:

- Smoking: 13.7% of residents smoke (similar to England 12.7%)[16].
- Obesity/overweight: 70.5% of adult residents are obese or overweight. (worse than London 55.9%, England 63.8%).
- Being physically inactive: 35% of residents (worse than London 22.9%, England 22.3%).

Wider determinants:

- Having low income (23.9% of children live in relative low-income families, (England 19.9%).
- Low educational attainment (Average Attainment 8 score age 15-16 is 49.9, similar to England 48.7; 22.7% have no qualifications (higher than London, 16.2%)[17].
- Living in deprived areas. (62.4%[18] of households are subject to 1 or more forms of deprivation, the highest level of deprivation experienced by any London borough).
- Psychological distress: Time lived in country of residence, financial stability and regularity of contact with family and friends are all protective factors for this in urban settings[19].
- Reduced access to health care. Average journey times to hospital for Barking and Dagenham residents are public transport 33 minutes; cycle 25 minutes; car 17 minutes; walking 56 minutes.[20]
- Food insecurity: 26.7% of Barking and Dagenham pupils are eligible for free school meals[21].

Demographics[22]:

- Being older (above 35 years). Currently 53.4% of the population is under 35, but as they age the likelihood of good self-reported health will reduce.
- Ethnic minority status (55.2% of residents are non-white).
- Being single (57.3% of adult residents are single or separated/widowed).

As the research identifies long term conditions, are one of the most important contributors to healthy life expectancy; demands on health social care services, and with concerted effort at place, impacts can be seen in the next 5 years.

Long Term Conditions

Long term conditions (LTCs) – also called chronic conditions – are health conditions for which there is no cure and require management through medication or other treatment. Therefore, identifying someone with a condition and getting them onto treatment programmes is vitally important.

As long-term conditions increase, what was once considered a health issue is now a societal one and needs a societal response requiring a focus on wider determinants of health.

Around 15 million people have a long-term health condition in England, including over half (58%) of us by the age of 60[23]. This impacts all aspects of life for individuals and communities, e.g.:

- **Employment** – e.g. over 1 in 3 working age people have a long term condition, with 2.5 million people not working nor looking for work as a consequence[24].
- **Demand for health services** – e.g. 50% of GP appointments, 64% of outpatient appointments and over 70% of inpatient bed days are for people with long-term conditions[25]
- **Cost of health and social care – e.g.** £7 in every £10 of health and social care funding is spent on treatment and care of long-term conditions[26]
- **Impacts on friends, families and communities** – e.g., almost 1 in 10 (9%) of the population provide care for someone[27] with a cost to their own health, social and economic wellbeing (e.g. caring results in a £6-9k drop in annual income for a carer[28])
- **Social participation and wellbeing –** e.g. 1 in 6 people with a LTC find it difficult to find or stay in work, 1 in 2 say it reduces their ability to maintain social relationships[29]
- **Susceptibility to illness and worse outcomes –** e.g.: 90% of COVID-19 deaths were in people with LTCs
- **Informal caring** – 52% of carers have a long-term health condition, with 87% reporting health has impacted their caring responsibilities[30]

Modelling by the Health Foundation suggests that there will be 2.5 million more people in England with a major illness by 2040; 1 in 5 adults compared to 1 in 6 currently. Although mostly driven by an ageing population (i.e. 80% of the increase will be in people aged 70 years and over), ill health is increasing across all ages. The 37% increase in people with major conditions is nine times the rate at which the working age population (20-69 year olds) is expected to grow, creating additional pressures on how to care for and fund a growing population with high health needs.

Increasing multiple long term conditions

Historically, focus on long term conditions has taken a single condition focus (e.g. strategies, funding, etc.); however, that is not the reality. Increasingly people are suffering from 'multi-morbidity, which is the presence of two or more health conditions[31]. Multiple long term conditions is associated with[32]:

- Reduced quality of life and life expectancy.
- Mental health difficulties, such as anxiety and depression.
- Higher treatment needs and use of services (including unplanned or emergency care).

Inequalities in Long Term Conditions

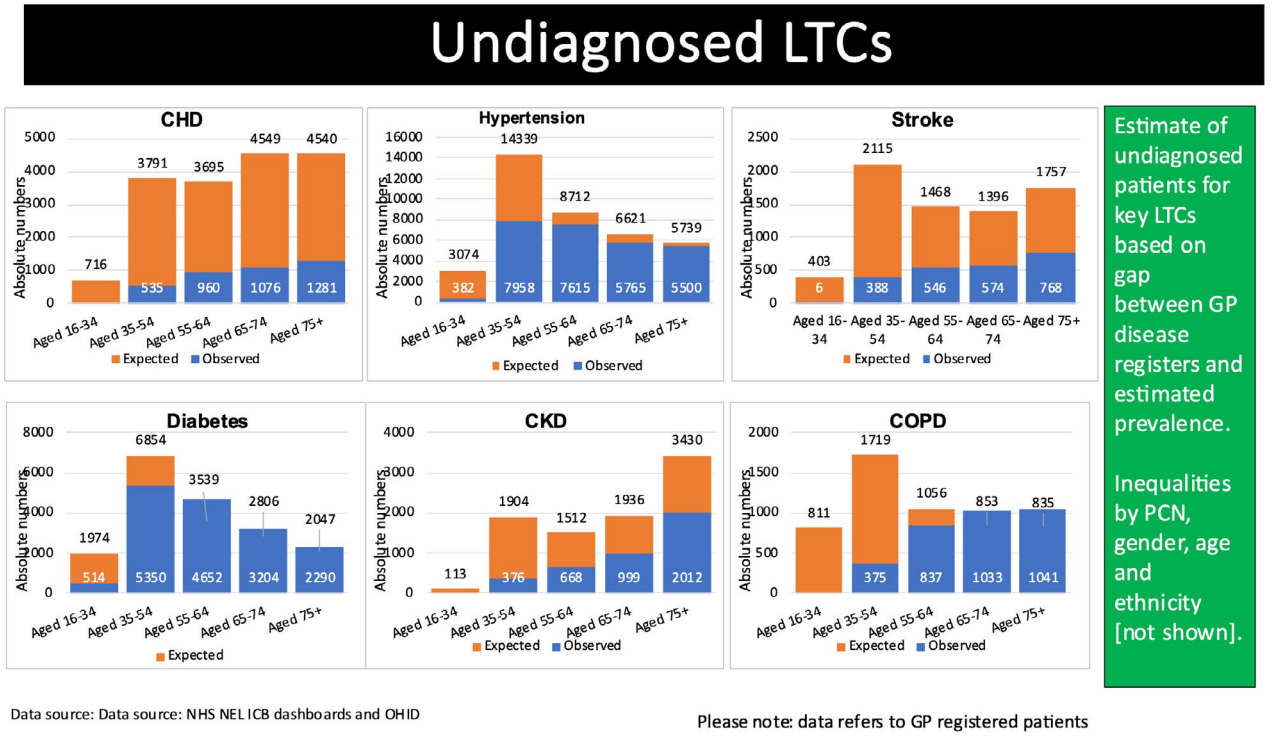
There are inequalities across all aspects of long term conditions: risk factors for developing a condition, likelihood of having a condition, risk of multiple conditions and management of that condition. These inequalities can be seen across gender, ethnicity, socioeconomics, etc.[33]

Residents and communities in Barking and Dagenham have a higher level of LTCs than their counterparts in other areas, ranking us worst in London for four of the 'top 10' health conditions; heart disease, chronic obstructive pulmonary disease, lung cancer and stroke[34], with almost 1 in 8 (13%) having two or more conditions[35]. Musculoskeletal conditions and mental health disorders caused the third and fourth greatest number of years of healthy life lost to disability, after cancer and cardiovascular disease (JSNA, 2022).

As health conditions amendable to secondary prevention, it is alarming to know that, by comparing the number of people we expect to have the six common LTCs versus those in treatment (based on being on a GP disease register) our findings suggest around 38,000 cases are unidentified and therefore unmanaged[36].

There appears to be inequalities by geography, genders (higher in males apart from chronic kidney disease (CKD)), age (highest in 35-54, except for coronary heart disease (CHD) and ethnicity (highest in White ethnicity, except for hypertension and diabetes).

Long term conditions are a major driver of health and social care needs in Barking and Dagenham



Data source: Data source: NHS NEL ICB dashboards and OHID

Please note: data refers to GP registered patients

Figure 11: Estimated number of undiagnosed long-term conditions in the borough, by type and age

In respect to multiple long-term conditions, Barking, Havering and Redbridge University Hospitals NHS Trust have also analysed LTCs across their three boroughs, including undertaking projections for the next 2, 5 and 10 years[37]. Analysis of 2022 found the highest number of avoidable deaths are in Barking and Dagenham; 37% and 54% higher than in Havering and Redbridge respectively. It also analysed use of acute services by people with LTCs, which was lower in Barking and Dagenham – which might be expected, having a younger population– and were driven (in order) by asthma, depression, diabetes, high blood pressure and cancer.

Table 2: Projections for key LTCs in Barking and Dagenham for 2, 5 and 10 years[38]

	18-64 years				65+ years				All ages			
	2023	**2 years**	**5 years**	**10 years**	**2023**	**2 yeas**	**5 years**	**10 years**	**2023**	**2 years**	**5 years**	**10 years**
Obesity	45,216	46,695	49,190	54,673	7,793	8,231	9,095	11,063	53,009	54,926	58,285	65,736
Hypertension	17,847	18,431	19,415	21,580	12,211	12,897	12,252	17,334	30,058	31,328	31,667	38,914
Depression	16,651	17,196	18,114	20,134	2,378	2,512	2,775	3,376	19,029	19,708	20,889	23,510
Diabetes	45,216	46,695	49,190	54,673	7,793	8,231	9,095	11,063	53,009	54,926	58,285	65,736
Asthma	7,035	7,265	7,653	8,506	1,877	1,982	2,191	2,665	8,912	9,247	9,844	11,171
CKD	1,594	1,646	1,734	1,927	4,064	4,292	4,743	5,769	5,658	5,938	6,477	7,696
% increase on 2023		**3**	**9**	**21**		**6**	**17**	**42**		**5**	**14**	**36**

Public Health Advice

To address long term conditions, we need to focus our efforts on:

- Reducing smoking and obesity by 2028 as they are primary risk factors associated with heart and lung diseases, cancers and diabetes.
- Identifying markers of early disease through improving identification of hypertension, high cholesterol and HbA1c blood levels, and identifying cancers early through the NHS screening programmes.
- Identify and tackle the health inequalities that exist within these risk factors.

What Are the Main Contributors to Mortality Rates?

However, although as explained earlier, focusing action on mortality rates will not impact as much on healthy life expectancy, as self-reported ill health, it is still important to recognise that deaths from cancer and cardiovascular disease make the largest contribution to years of life lost and therefore have the biggest impact on life expectancy; and tobacco is the risk factor making the largest contribution to years of life lost for both sexes followed by high body mass index (BMI), high cholesterol and high blood pressure. A recent analysis has shown that residents are around three times more likely to suffer an avoidable death than people living in the 10 least deprived areas of England[39].

Infant mortality is another key avoidable outcome impacting on healthy life expectancy, driven by perinatal maternal health and support received. Overall approaches to addressing health inequalities will impact on the health of women giving birth; as part of an overall approach to giving children the best start in life as highlighted in Chapter 5.

What Are the Health Inequalities Related to Healthy Life Expectancy?

Not only do we need to improve overall healthy life expectancy for females and males we also need to address the differences in healthy life expectancy experienced by our residents.

Last year's Annual Report highlighted the extent of health inequalities our residents and communities suffer.

The healthy life expectancy experienced by our residents is 58.1/60.1 years (males / females) compared to 63.8/65.0 and 63.1/63.9 years for London and England respectively, which means they will develop a life-limiting condition impacting their ability to undertake normal activities (e.g. work, see friends and family, etc.) five years earlier than their counterparts in other areas of London and England.

And healthy life expectancy is also not felt the same within the borough, with inequalities within communities that vary by outcome and risk factor. There is currently a 6.4 year difference in healthy life expectancy between the least and most deprived males and a 5.8 year difference between the least and most deprived females within the borough,[40] and residents of Black ethnicities develop a long term health condition over five years earlier than their White neighbours (Table 3), while life expectancy and deaths from certain diseases (e.g. morbidity in cancer, dementia and Alzheimer's) are highest in White residents.

Table 3: Age of the first health condition by ethnicity[41]

Ethnicity	1st condition (age)	2nd condition (age)	3rd condition (age)
BAME	54.1	60.3	63.6
Asian / Asian British	52.6	57.5	60.7
Black/African/ Caribbean/Black British	49.8	55.0	57.8
Mixed/Multiple ethnic groups	55.4	62.2	65.6
White	55.4	62.1	66.2

Ethnicity of residents with 1 known long term condition

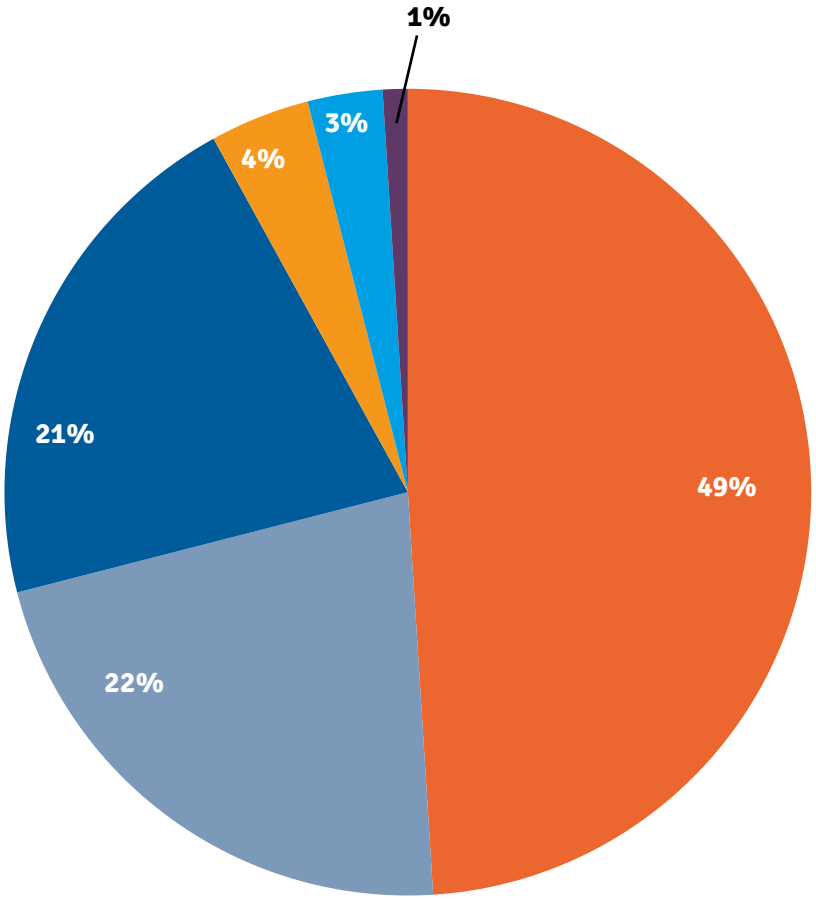


Figure 12: The percentage of residents with 1 known long term condition, by major ethnic group

Ethnicity of residents with 4 known long term conditions

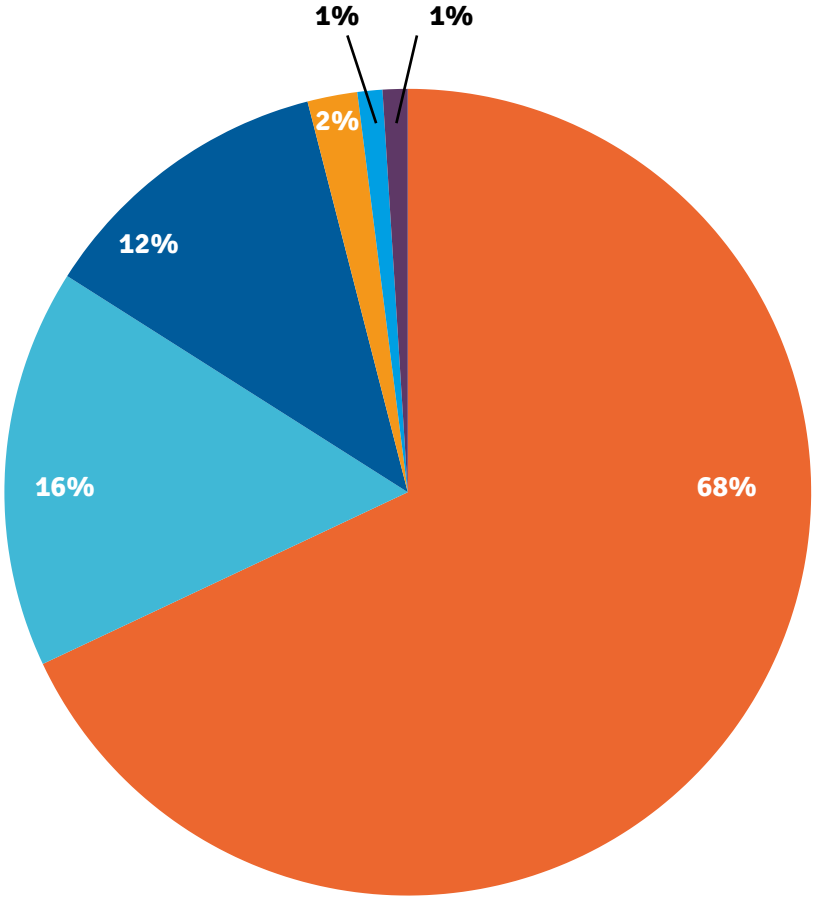


Figure 13: The percentage of residents with 4 known long term conditions, by major ethnic group

White
Asian or Asian British
Black or Black British
Other Ethnic Group
Mixed
Not Known

These inequalities are made worse by the cost-of-living crisis, reflecting the importance of addressing wider determinants of health alongside health behaviour and access to health services.

The key health risks associated with this are:

- Estimates suggest that some 10% of excess winter deaths are directly attributable to fuel poverty and 21.5% of excess winter deaths are attributable to the coldest 25% of homes.[42] Of note in 2021 15.3% of the population were in fuel poverty, worse than the London and England averages of 11.9% and 13.1% respectively. The number of deaths in the winter period was 78.9% higher when compared to non-winter period in 2020-2021; the third highest in the country.
- An increase of 1% in the percentage of households living in relative poverty is associated with a 6-month decrease in male healthy life expectancy[43].
- National analysis indicates prevalence of moderate to severe depressive symptoms was higher among adults who were economically inactive because of long-term sickness (59%), unpaid carers for 35 or more hours a week (37%), disabled adults (35%), adults in the most deprived areas of England (25%), young adults aged 16 to 29 years (28%) and women (19%). [44]
- Rates of mental health problems increased nationally during the pandemic and have still not recovered to pre-pandemic rates[45]. Estimated local prevalence of mental health problems in those age 16+ prior to the pandemic 2017 was 22.4%, higher than the England average (16.9%) and this is likely to have been exacerbated by recent events.
- Rates of economic inactivity and unemployment from 2021/22 in Barking and Dagenham were higher than London and England average locally, with 67.6% in employment compared to 75.2% and 75.4% respectively.[46] As a report from ONS[47] identified; the number of people economically inactive because of long term sickness has risen to over 2.5 million people, an increase of over 400,000 since the start of COVID-19. And for those economically inactive because of long term sickness, nearly two-fifths (38%) reported having five or more health conditions (up from 34% in 2019), suggesting that many have interlinked and complex health issues.

Last year's report also referred to the risk to health and health inequalities of the 'Cost of Living Crisis', with our residents who are amongst the most vulnerable due to underlying issues (e.g., food insecurity, fuel poverty, child poverty, economic inactivity, etc.). As stated, it takes time for impacts to be seen in outcomes and data, but we can see the impact through increasing need for services.

All services and support provided by the council, NHS and community report increasing need and demand for services. For example, data from Citizens Advice highlight issues for residents include:

- **High energy costs** – By end March 2023, energy debt was the most common type of debt that the local Citizens Advice helped residents with, whereas it used to be rent or council tax arrears.
- **Need for crisis support** – Residents requiring crisis support (e.g. food banks) doubled in Q4 2022/23 compared to the previous year (13.54 people per 10,000 compared to 6.17 in Q4 of 2021/22)
- **Disproportionate impact on vulnerable people** – More than 60% of the people Citizens Advice have helped with crisis support nationally have been disabled or had a long term health condition.

Our Resident's Survey has also recorded the lived experience of residents suffering, e.g. the July-August 2023 Survey highlighted:

- **Inability to cope** – Almost 1 in 3 (31.2%) of residents reported that their living costs had increased and they were no longer able to cope; twice the proportion of the previous year's Survey.
- **Debt** –Just under 2 in 3 residents (59%) had to borrow from families and friends to pay bills, whilst many residents have also had to borrow from legal and illegal money lenders.
- **Inability to live healthily** – Over 1 in 2 residents (52%; versus 15.6% nationally) have smaller or skip meals due to cost and over 1 in 5 (21%; versus 10.9%) have been hungry but not eaten as could not afford or access food.

Public Health Advice

To increase the number of years residents spend in good health, we should focus our collective resources into:

- Enhancing our early diagnosis programmes, that target key cohorts of residents, supported by assessable and culturally appropriate chronic disease management programmes.
- Reducing the high levels of smoking and obesity.
- Reducing mortality rates associated with cardiovascular disease and cancer.
- Addressing the variation in health and social care outcomes experienced within and between our communities in each of these areas.

Chapter 4:
Action To Increase Healthy Life Expectancy and Address Health Inequalities

To improve healthy life expectancy, we need to create foundations for self-reported good health and tackle the more direct causes of mortality; with a focus on the local challenges.

This chapter sets how and what we need to do to address the key contributing factors to healthy life expectancy, identified in chapter 3:

- Long term conditions
- Key behavioural risk factors
- Wider determinants of health – developing the building block for good health

How to Address the Problem of Long-Term Conditions

The figures on long term conditions in the previous chapter are worrying and show England & Wales have amongst the worst population health in Europe, particularly so in Barking and Dagenham. However, we can do something about it.

The Government has published the case for change and strategic framework for the National Major Condition Strategy. It focuses on prevention, earlier diagnoses and treatment for six groups of major health conditions responsible for 60% of death and illness in England: cancers; cardiovascular disease, musculoskeletal disorders, mental ill health, dementia and chronic respiratory disease. It also identifies five areas for action to have the greatest impact over the next five years (Figure 14), which need to shape our Place based Partnership response.

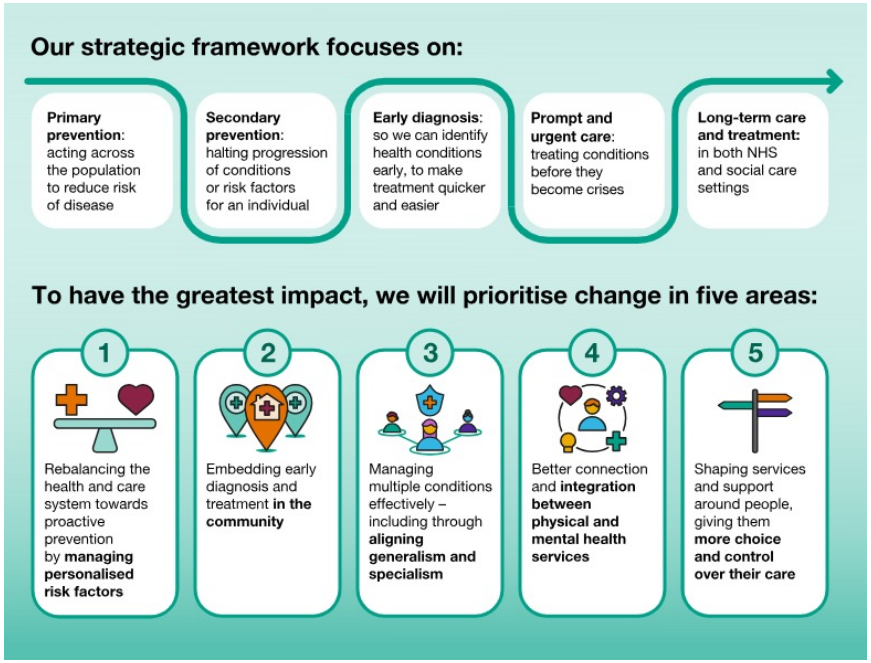


Figure 14: National Major Conditions Strategy strategic framework

The National Institute for Health and Care Research has also published an evidence review on multi-morbidity which found:

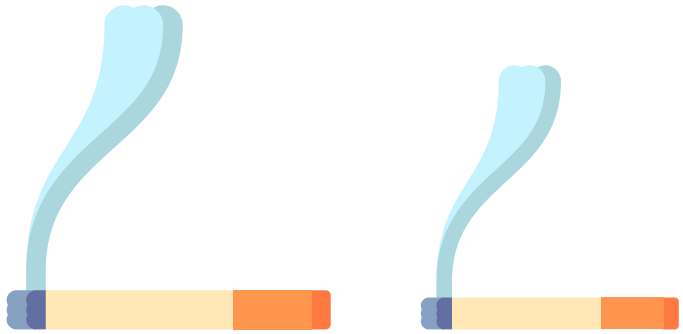
- Complexity and difficulty in accessing and navigating services, with a strong desire for greater service integration and coordination.
- Tendency for services to focus on symptoms and conditions and fail to see the things that matter to people. There is a need for more person-centred, holistic care.
- People felt that their mental health needs and emotional wellbeing were frequently ignored, which often resulted in a worsening of symptoms. Mental health services should be offered at the outset.

Addressing Long Term Conditions in Barking and Dagenham

The key contributor to our poor female and male healthy life expectancy is the prevalence of long-term conditions within our borough. This is recognised and prioritised by the Barking and Dagenham Local Joint Health and Wellbeing Strategy 2023-28.

At north east London level, addressing long term conditions (LTCs) is central to NHS North East London's (NHS NELs) Health and Care Partnership approach. LTCs are one of the four priorities in NHS NELs interim Integrated Care Strategy, which also includes Tackling health inequalities, Prevention, Personalised Care and Co-production with local people as cross-cutting themes. NHS NELs Joint Forward Plan places LTCs as a strategic priority and calls for greater focus on prevention and addressing unmet need (specifically on child obesity, mental health, tobacco and premature cardiovascular disease deaths).

To address the early identification of risk factors and early diagnosis of cardiovascular related conditions is the NHS Health Check. Our offer of an NHS Health Check is provided through General Practice and engagement activities at borough events. A nine-month pilot for the eligible 30–39-year-olds was carried out in 2022/23 by Together First, with positive health outcomes. Plans to reinstate the programme in our community pharmacies is currently in place, as a pilot.



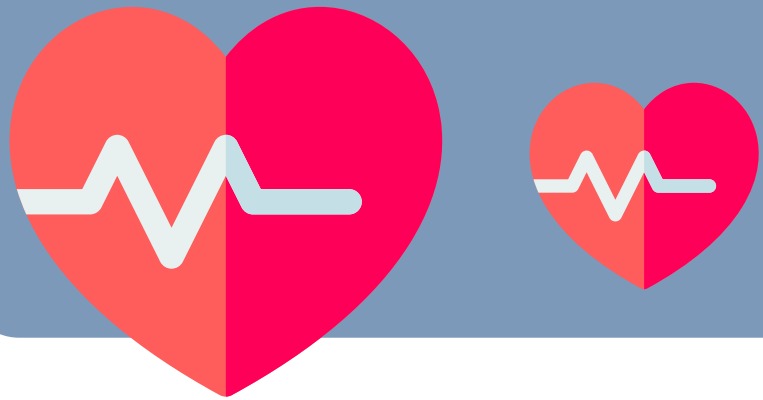
However more needs to be done to find many more residents who we estimate are likely to have one or more long term condition but have not yet been diagnosed (see our analysis in the 'Inequalities in Long Term Conditions' section). We need to agree a single, multi-agency active case finding plan to identify these residents and enhance our efforts and programmes for LTC early diagnosis, by:

- Continuing to work with primary care to support our general practices to improve early diagnosis of key LTCs.
- Agreeing prioritisation of long-term conditions where data and evidence increase scale and pace of action to deliver the greatest health benefits (e.g. hypertension).
- Encouraging our general practices to identify patients aged 14 and over with learning disabilities, to maintain a learning disabilities 'health check' register and offer them an annual health check, (as recommended by NICE, 2016).
- Delivering Phase 2 pilot of 30–39-Year-Old targeted NHS Health Check service, offering more opportunities on reducing differences between people and communities from different backgrounds.
- Continuing to provide health checks through engagement activities at borough events and outreach.

Case Study: Targeted Case Finding by Together First

Taking the Public Health team's estimate of the number of residents in the borough with undiagnosed long-term conditions as a starting point, the GP Federation Together First CIC set up a case finding project to find and treat residents across five disease areas. General Practice went through Clinical Effectiveness Group searches to identify patients who were not on disease registers but appeared to have symptoms of one or more of the following conditions: coronary heart disease, chronic kidney disease, hypertension, chronic obstructive pulmonary disease and asthma.

Patients were then invited in for a check-up and tests undertaken to confirm diagnosis. The pilot of this case finding work over spring 2023 uncovered 718 diagnoses of hypertension and 215 new cases of chronic kidney disease. Evaluation was undertaken by Together First and recommends exploring a mobile unit and having blood pressure monitoring in community venues, along with working with partners to identify other approaches to attract residents for checks.

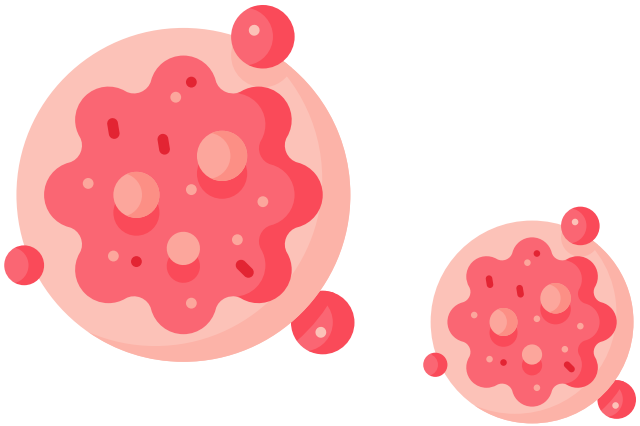


Identifying Cancer Early

Cancer although not classified as a long-term condition does have significant impact on mortality rates in Barking and Dagenham, and therefore identifying cancer early to improve treatment outcomes is important.

The North East London Cancer Alliance works to improve and transform cancer patient pathways from prevention through to treatment and survival. The ambitions of the NHS Long Term Plan are to diagnose 75% of cancers at stage 1 or 2 and increase the number of people surviving cancer for more than a year by 55,000 by 2028.

Cancer Screening is the process of identifying healthy people who may have an increased chance of a disease or condition, to reduce associated problems or complications (UK National Screening Committee, 2023). Improving uptake is a regional priority for NHS England - London.



Cancer Screening Programmes performance in Barking and Dagenham:

Our bowel cervical and breast cancer, screening uptake rates are all significantly worse than England averages.[48]

Bowel cancer screening: the current uptake in Barking and Dagenham is lower than the expected uptake in London of >60%.

Breast cancer screening: The uptake in the outer north east London boroughs increased significantly from 48.5% in Q1 22/23 to 68.5% in Q2 22/23 (highest in London), because the service started sending second timed appointments for all women that did not attend their appointment.

Cervical cancer screening: There has been no increase in coverage.

We are working with NHS North East London to improve the uptake of screening and improvement in coverage across the borough, aligned to public information so our residents know what they can do to reduce the risk of developing cancer.

We need to do the following to improve uptake:

1. Cervical Screening

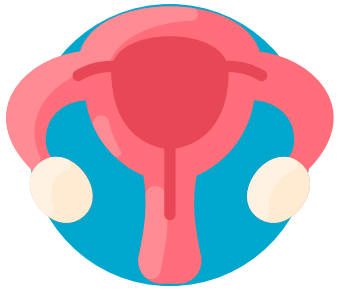
- Work with general practices to support and promote the universal MSM human papillomavirus (HPV) vaccination programme for eligible adolescents and gay, bisexual, and other men who have sex with men (GBMSM) aged under 25 years.
- Support Vaccination UK to deliver the HPV vaccines to Year 8 students in January 2024 in all schools in the borough.
- Work with comms/engagement channels to support and promote the HPV vaccination programme.
- Support practices to promote the HPV screening tests in areas with low uptake.

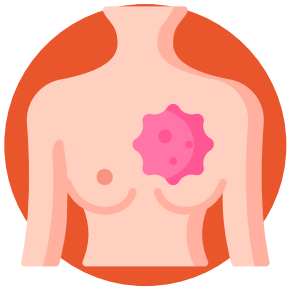
2. Breast Screening

- Support NHS InHealth and partners to promote the mobile Breast Screening Units every 3 years in Barking and Dagenham.
- Support NHS InHealth's ongoing engagement activities and promotional work at borough events/outreaches and strengthen Breast Cancer Nurse Specialist's links in with Primary Care Networks.
- Build a strong partnership between public health, general practices and community organisations to raise awareness of breast screening.
- Support the current project to improve uptake for women with severe mental illness funded by NEL Cancer Network.
- Help practices promote breast screening at the InHealth Group fixed clinic for residents in areas with low uptake.

3. Bowel screening

- Have health promotional materials and information available in languages most suitable for the borough.
- Work with the Bowel Cancer Borough Lead, to continue to investigate barriers faced by men that prevent them from participating in screening and use this information to develop solutions.
- Support the annual NHS Bowel Cancer Screening Campaign in London in delivering the community outreach, to increase awareness of the home testing kit and increase uptake across ethnic minority groups.
- Support practices to increase uptake across all ages and target key areas of low uptake.





How To Address the Behavioural Risk Factors of Low Healthy Life Expectancy

As I have regularly highlighted, a long-term system wide place-based approach is required to achieve population level health outcomes. Action is required across three types of interventions (i.e. the Population Intervention Triangle): Civic-level interventions (e.g. licensing, economic development); Community-based interventions (e.g. using and building assets within communities); and Services-based interventions (e.g. quality and scale, reducing variation).

Service based interventions to support the reduction of weight, smoking cessation and to promote physical activity have the potential to generate population-level change but this is often not achieved for several reasons, mostly:

- Differences in service quality and delivery (effectiveness; efficiency and accessibility).
- Variability in the way the population uses those services (based on knowledge, skills and health-seeking behaviours and resources) - and therefore variable needs for support to use those services appropriately.

Therefore, high-quality services can reduce unwarranted variation in outcomes, but they will not reduce inequalities at a population level unless they also identify and (with partners) give **graduated and targeted support to the populations in greatest need**, who are not using those services to best effect. The level of health inequalities experienced in Barking and Dagenham means that alongside providing high quality services, direct action is needed to address the needs of underserved populations.

We recently reviewed our weight management, smoking cessation and exercise on referral services against these principles and the main findings were:

- The need to develop strong place-based leadership.
- A need for a system wide approach to the issue, for example tackling smoking cannot ignore the legislative requirements of enforcement and addressing obesity must tackle the obesogenic environment we live in.
- More robust outcome commissioning and contract monitoring.
- Better targeted services to meet underserved populations and
- A stronger focus on delivering evidence-based practice.

The review also looked at **social prescribing** as a key part of Universal Personalised Care through which local agencies can refer people to a link worker for holistic support to address their health and wellbeing needs. Our findings identified that we need to take a more strategic look at how the service could play an important part in promoting healthy behaviours and providing support to personalisation and anticipatory care in social care, to help manage demands. An internal council review of evidence-based opportunities to improve anticipatory care suggested a range of actions across the themes of maximising resourcing and efficacy; and realising a focus on social care within Place and integrated care.

As muscular skeletal conditions are one of our key causes to loss of years due to disability, we need to consider the anticipatory care offer to reduce frailty, falls and loss of independence to manage demand on our services.

What is anticipatory care and personalisation aiming to achieve?

Anticipatory Care aims for patients who are at high risk of unwarranted health outcomes to live well and independently for longer, through structured proactive care.

Personalisation aims for every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings.

Since the review on our services, we have received the following direction on smoking cessation.

Stopping the start: a new plan to create a smokefree generation

In October 2023, the Government set out a new ambition to create a smokefree generation in the 'command' paper, to raise the age of access to tobacco one year every year, to prevent smoking before it starts.

The command paper sets out policy proposals for additional funding: to local Specialist Smoking Services to support smokers to quit, for awareness raising campaigns, for a national Swap to Vapes Scheme to stop smoking, and financial incentives for pregnant smokers to quit. Enforcement: there will be additional funding proposed for Trading Standards, Border Force, HMRC; on spot fines to be introduced and online age verification.

This will provide an additional 58k ring-fenced funding for Stop Smoking Services (28% increase) from 2024/25 to 2018-29 and an opportunity to participate in a 'Swap to Stop' pilot (which we have submitted an expression of interest for).

How To Create Building Blocks to Improve Healthy Life Expectancy

Creating Healthy Places

For us to be healthy, the building blocks of good health need to be in place in our communities – things like decent homes, good school and sound business practices. When these building blocks of health are weak or missing, our health can suffer: for example, when businesses promote unhealthy products like alcohol and junk food.

We need to balance our supporting to individuals to change their behaviour with creating healthy places for everyone[69]

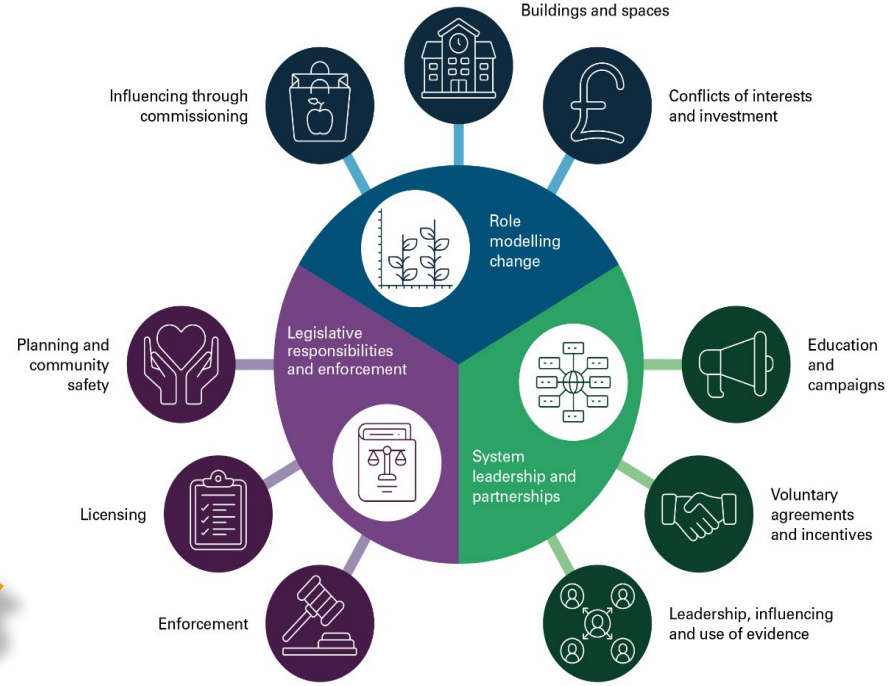


Figure 15: Tackling tobacco, alcohol and unhealthy food: A framework for local authorities[49]

The council is in a unique position to create healthy places, using opportunities combining statutory responsibilities, broad priorities, and local relationships – including with communities, businesses and with our place-based partnership. Due to the complexity of public health challenges, there is also a need for involvement and collaboration between council directorates and teams by taking a health in all polices approach. This means embedding a health lens across council services and decision making.

In London, 68% of residents live in areas (measured at levels called lower super output areas which translate to approximately 1000-3000 residents) which are in the worst performing 20% of environments in the region for access to health promoting and health demoting factors[50];

including: access to retail services (fast food outlets, gambling outlets, pubs/bars/nightclubs, off licences, tobacconists), access to health services (GP surgeries, Emergency Department hospitals, pharmacies, dentists and leisure centres), the physical environment (access to green spaces, and three air pollutants: nitrogen dioxide (NO2) , airborne particulate matter (PM10), sulphur dioxide (SO2) levels). This means that people's homes are clustered in the unhealthiest environments. We plan to map this in the 2024 JSNA.

There are clear opportunities to use development and council management to create healthier environments. For some determinants there are clear links to improvements in healthy life expectancy that may be achieved in the next 5 years; and opportunities to build on existing strengths.

Example: Housing and Health

A recent study identified that challenging housing circumstances negatively affect health through faster biological ageing. However, biological ageing is reversible, highlighting the significant potential for housing policy changes to improve health[51]. We have also highlighted the links between fuel poverty and healthy life expectancy (ref). More immediate effects can be seen through damp and mould worsening respiratory disease (ref) and overcrowding enabling easier spread of infectious disease.

Local authorities have levers through planning, licensing and enforcement to regulate housing quality and there are emerging areas where we can focus and develop work to mitigate against the health risks associated with poor housing:

- Work is currently underway to ensure damp and mould issues are resolved quickly and to support education for landlords alongside enforcement in the housing sector.
- The Healthy New Towns principles have been embedded into Barking Riverside regeneration plans.
- A homelessness Health Needs Assessment is underway to understand how best to support this vulnerable population in partnership with health pop up clinics with our NHS partners.

Other key opportunities include:

- Targeted work to help residents with long term conditions and disabilities gain and stay in employment, building on our existing local pilots.
- Work to support residents most vulnerable to the cost-of-living crisis.
- Using our connections with communities to establish connection, trust and belonging; aligned with the work of the BD Collective. For example, we are currently funding a health and faith initiative, co-producing health promotion projects with faith communities.
- Creating healthy streets that encourage walking and cycling, and safe streets around school zones.
- Reducing and mitigating the impacts of air pollution through a combination approach of transport, planning, industrial and behavioural interventions.[52]
- Supporting local health partners to develop as anchor institutions.[53]

Mental Health and Wellbeing

Good mental health is a key prerequisite across all factors impacting on healthy life expectancy, as well as people who have poor mental health are more likely to have higher health risk behaviour and suffer a long term condition, often due to the same pathways that influence both [54]

Our mental health incorporates mental illness, psychological distress and mental wellbeing (the positive aspects of mental health).

There are considerable inequalities in life expectancy for those with serious mental illness. Barking and Dagenham residents with severe mental illness are over three times as likely to die prematurely than those without.[55]

However, the burden of psychological distress and common mental disorders (anxiety and depression) will cause a greater impact on healthy life expectancy overall. Additionally, as recognised by the Major Conditions strategy, mental and physical illness are inextricably interlinked[56]: Residents with physical health problems, especially long-term conditions, are at increased risk of poor mental health, particularly depression and anxiety. Around 30% of residents with any long-term physical health condition also have a mental health problem. Poor mental health, in turn, exacerbates some long-term conditions, such as chronic pain, as well as being linked to unhealthy behaviours such as disordered eating, alcohol consumption and smoking.

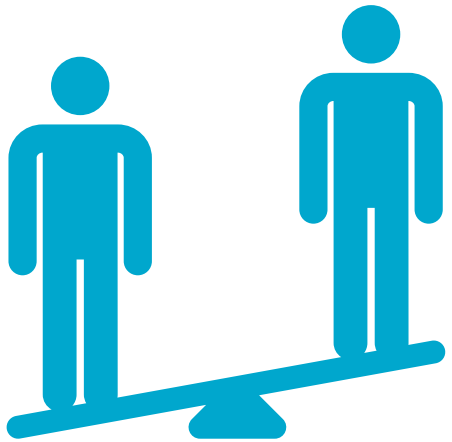
The determinants of mental health are in many ways the same as for physical health, but a greater importance is placed on the relationships around us in families and communities; our position in society and exposure to stressors such as abuse, discrimination, or financial hardship: many of our residents will be vulnerable to these stressors.

Prevention needs to start young: Half of all mental health problems have been established by the age of 14, rising to 75% by age 24.[57]

Addressing mental health therefore, needs to feature across work on long term conditions, inequalities and the best start in life, as well as building healthy places.

Addressing Health inequalities

The flipside of great need is the exciting potential to make improvements, and our health inequalities programme is making steps to develop an evidence-based 'whole place' approach. Yet there are few 'quick fixes' in health inequalities, so there is the need to coproduce, identify and invest in 'what works' to make tangible improvements in the medium and long terms. But targeting our action to address inequalities in cardiovascular disease, respiratory disease and diabetes, smoking and obesity will provide short term gains.



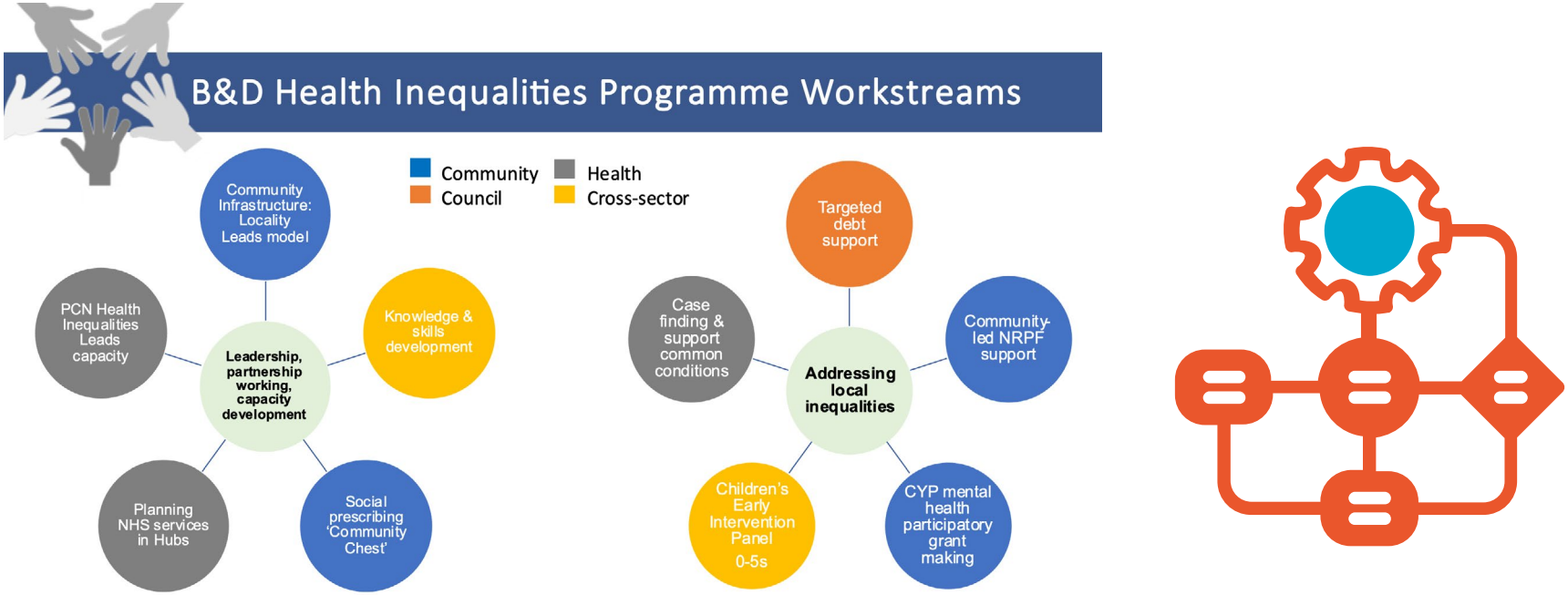


Figure 16: Summary of the Health Inequalities Programme 2022-23

The programme is in its first year of delivery several agreed milestones have been achieved:

Improved place working & action on health inequalities:

- Establishment of Community Locality Leads and Primary Care Network Health Inequalities Leads providing strategic and practical leadership for and between community and primary care sectors.
- 80% of professionals involved in the Place-based Children's Early Intervention Panel reported good, very good or excellent shared understanding of workforce behaviours across the partnership that lead to positive outcomes.
- 95% of Adult Social Care staff who attended Trauma Informed Practice training and completed the post course evaluation felt confident or very confident to apply the practice.
- 97% of frontline workers in statutory and voluntary sector working with residents with No Recourse to Public Funds (NRPF) said the local NRPF guidance significantly enhanced their awareness of local services and 96% agreed it significantly improved understanding of the needs of residents with NRPF.

Services-led health improvement & inequalities reduction:

- 933 residents have been identified and assessed for undiagnosed / unmanaged health conditions.
- 213 residents with unidentified low level mental health issues were proactively contacted and a total of 80 holistic support interventions were delivered.
- All professionals who presented a family of concern to the Children Young People Early Intervention Panel for 0-5s said it left them more confident in the next steps with a family and many said they got families on their caseload access to appropriate services in a time effective way.

Community-led health improvement & reduction:

- Community mental health interventions by local community groups achieved improvements of their mental wellbeing (a one-point increase in their score on the Short Warwick-Edinburgh Mental Wellbeing Scale).
- 15 community organisations received funding through the Community Chest for Social Prescribing, 10 of which were global majority led and nine of which had never received external funding before.

Case Study: Understanding the Needs of Residents with Special Educational Needs and Disabilities

One approach to addressing inequalities across a population is to focus on those with the worst outcomes, not just to act equitably but by improving support for the most underserved you can improve access to support for all.

For example, people with learning disabilities die 22-26 years younger than the general population, with 49% of deaths rated as 'avoidable' (over twice the 22% in the general population)[58]. Significant inequalities can also be seen within the population of people with learning disabilities, with an average of death of 34 years for people with learning disabilities of non-White ethnicities compared to 62 for their White counterparts[59].

Consequently, the Barking and Dagenham Public Health Team recently led a cross-sector educational and health needs assessment for residents with Special Educational Needs and Disabilities (SEND), which will include those with learning disabilities.

Currently, proportions of pupils in Barking and Dagenham accessing SEND support (12%) are like London but lower than England averages; but proportions of pupils with Education Health and Care (EHC) Plans are lower than London averages. Over the past 5 years (2018-2023) proportions of pupils with SEND support or EHC Plans have been increasing locally, regionally and nationally.

Assuming trends to date are maintained; the following projections can be made:

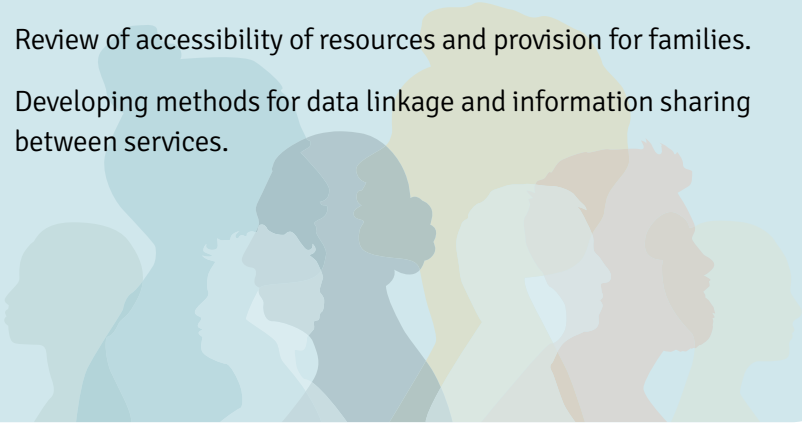
- The total number of pupils in primary, secondary and special schools combined on an EHC Plan is projected to rise threefold between 2018 and 2035 – this is faster than the rate of increase in the school population based on GLA projections.
- The total number of pupils on Special Education Need support is predicted to rise by 27% between 2018 and 2035, which is more aligned with increases in school population sizes.

There are several risk factors in the borough that could drive increases in SEND needs, including increasing ethnic variation and deprivation.

The existing challenges to delivering support that families need: shortages linked with difficult recruitment and retention of specialist staff; delays in obtaining EHC Plans and in effective multidisciplinary communication; and lack of clarity on the local offer.

The current and new challenges will require both additional provision and new ways of working to address this, including:

- Improving the accessibility of the local offer for families.
- Improving EHC Plan processes.
- Development of integrated care pathways.
- Early intervention to prevent escalation of problems; in particular for Speech, Language and Communication needs.
- Work to enhance recruitment and retention of specialist staff; and upskill wider health and education staff to support families.
- Review of accessibility of resources and provision for families.
- Developing methods for data linkage and information sharing between services.



Public Health Advice

To improve healthy life expectancy the evidence suggests the following action:

- Take a place-based approach to address early identification and early treatment for people with long term conditions:

  - to ensure all residents with a health condition are identified and are supported to manage their condition.

  - that addresses social, economic, and physical environment that causes our residents to make decisions that damage their health and lead to long term conditions, such as those driving obesity through unhealthy diets and lack of physical activity.

- Provide a targeted support programme to residents to address obesity and smoking.
- Address wider determinants of health for example to insulate and remove damp and mould in homes; support people with long term conditions or disabilities, including young people with special educational needs and disabilities to gain and stay in employment, and mitigate the health harms of the cost of living crisis.
- Improve mental health and wellbeing as an underpinning factor.

To address underpinning health inequalities, we need to:

- Develop a shared understanding of health inequalities, its drivers and local priorities (including across our population groups and geographic areas) to direct decision making and action.
- To align the NHS's mandated duty to address health inequalities with the overall place-based programme.
- Work with NHS North East London on their Healthy Equity Academy and their evolving Health Equity Fellowship (including extending beyond the NHS to create analogous community sector fellowships).
- Continue and expand cross-sector action on the ongoing health legacy of COVID-19 and impacts of the cost of living crisis that are increasing health inequalities for residents.
- Ensure a 'health in all policies approach' in which all systems partners are engaged to understand and address the role of health inequalities in driving community priorities (e.g., employment).

Chapter 5:
Best Start in Life - The Building Blocks for a Healthy Life

KEY FACTS

Approximately 57,150 children are under 16 in the borough (the highest proportion in England and Wales) and we have the highest proportion of children aged 0-5 in the UK (8.8%).

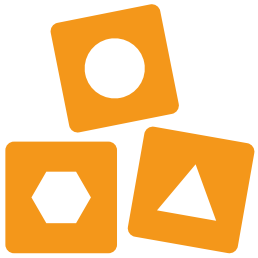
In 2021/22, only 6 in every 10 of Barking and Dagenham's children achieved a Good Level of Development (GLD) by the end of Reception year (for those children on free school meals, it was only 5 in 10).

Children who score badly on school readiness at the age of 5 are far less likely to succeed in secondary school – and far more likely to experience poor health and low pay as adults (Save the Children, 2018).

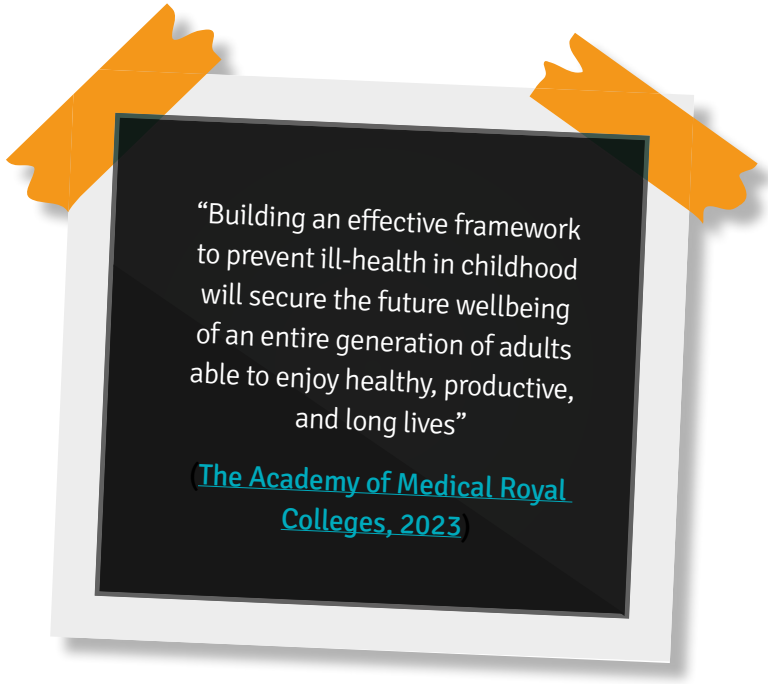
In 2022/23 just under half of our Year 6 children were overweight or obese (the 3rd highest rate in England and the highest in London).

Individuals who have adverse childhood experiences (ACEs) during childhood or adolescence tend to have more physical and mental health problems as adults and more likely to have an earlier death (Hughes et al., 2017).

The National Child Mortality Database (NCMD) recently reported the death rate in England for white infants has stayed steady at about three per 1,000 live births since 2020, but for Black and Black British babies it has risen from just under six to almost nine per 1,000. Death rates also doubled in more deprived areas compared to non-deprived, and the mortality for Asian and Asian British babies rose by.



A large part of this report has been focusing on actions which relate to adults and actions that can affect short term change, but action across the life course is important - today's children will be tomorrow's adults, and the things that happen to them in childhood can shape the trajectory of their health across childhood, into adulthood and throughout adulthood into older age. We need to maintain a focus for children to improve the health outcomes for our general population across the life course. It is significant to note that the JSNA, 2022 shows Barking and Dagenham has a very young population which has increased significantly over the past decade (17.7% total population increase since 2011 census – second highest increase in London).



The council's Corporate Plan, Joint Local Health and Wellbeing Strategy and Best Chance Strategy (for babies, children and young people) all have the best start in life as a key priority, alongside reducing inequalities and giving our children and young people opportunities to achieve.

Risk Factors for Ill Health

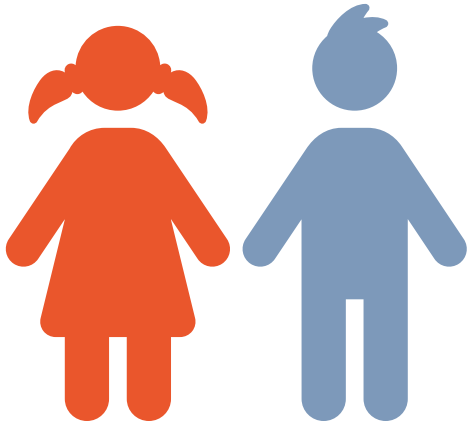
In 2022/23 around 45 in 100 year 6 children were overweight or obese (45.4%) – this was the 3rd highest rate in England and just under a quarter of our Year R children were overweight or obese (24.0%). Both are the highest in London. The evidence suggests that children who are overweight or obese are likely to stay obese into adulthood and to develop long term conditions like diabetes and cardiovascular diseases musculoskeletal disorders, especially osteoarthritis; and certain types of cancer (endometrial, breast and colon) (World Health Organisation, 2020).

Investing in Early Years

But how we treat young children also shapes their lives. If we get the early years right, we pave the way for a lifetime of achievement. The first 1001 days from conception to age 2 is widely recognised as a key period in the life course of a developing child, providing a unique opportunity for professional involvement because it is the time when parents are often the most receptive to behaviour change interventions and where the evidence suggests it is most effective.

Figure 17: An example of the return on investment in school readiness

"The highest rate of return in early childhood development comes from investing as early as possible, from birth through age five, in disadvantaged families. Starting at age three or four is too little too late, as it fails to recognize that skills beget skills in a complementary and dynamic way. Efforts should focus on the first years for the greatest efficiency and effectiveness. The best investment is in quality early childhood development from birth to five for disadvantaged children and their families."— James J. Heckman, 2012



Preparing Children for School

Ensuring children can get the best from education is vital; too many of our children are not starting school with the range of skills they need to succeed. Educational attainment is one of the main markers for wellbeing through the life course and so it is important that no child is left behind at the beginning of their school life. School readiness is a strong indicator of how prepared a child is to succeed in school cognitively, socially and emotionally, and it links to educational attainment, which impacts on life chances – having been shown to impact on health, future earnings, involvement in crime, and even death (Public Health England, 2015).

Children who score badly on school readiness at the age of 5 are far less likely to succeed in secondary school – and far more likely to experience poor health and low pay as adults (Save the Children, 2018).

School readiness is a key area for inequality – with more children from deprived backgrounds not being school ready, and a lack of school readiness contributing to further inequalities across the life course. There is a pronounced social gradient in early language development, with more young children from disadvantaged backgrounds having poor language skills (Public Health England, 2015). Nationally, children from the poorest homes are a year behind in their language and literacy skills by the age of 5 (Save the Children, 2018). In 2021/22, only 62.5% of our children achieved a good level of development (GLD) by the end of Reception year.

For children eligible for free school meals, only 51.8% had reached their key development milestones by this time
. Children who have a special educational need or disability (SEND) are also less likely to achieve a GLD by the end of reception year (The British Association for Early Childhood Education, 2022). The gap in language and communication among children in reception classes continue and widen throughout the school years. Over half of the inequality in learning outcomes at age 11 can be traced back to the pre-school years.

Figure 18: A summary of the importance of school readiness

Adverse Childhood Experiences

The experiences we have early in our lives, particularly in our early childhoods, have a huge impact on how we grow and develop, our physical and mental health, and our thoughts, feelings and behaviours.

Barking and Dagenham have some of the highest rates of child poverty in London, high levels of domestic abuse, high demand for social care, and high rates of homelessness amongst families with children – so the exposure of our children to potential adverse childhood experiences (ACEs) is significant. The cost of living crisis in the UK is worsening physical and mental health outcomes for children and young people and worsening health inequalities (Academy of Medical Royal Colleges, 2023).

Individuals who have ACEs during childhood or adolescence tend to have more physical and mental health problems as adults and more likely to have an earlier death (Hughes et al., 2017).

One study suggested that 12% of binge drinking, 14% of poor diet, 23% of smoking, 52% of violence perpetration, 59% of heroin and crack cocaine use and 38% of unintended teenage pregnancy prevalence nationally could be attributed to ACE experience below the age of 18 (The Institute of Health Equity, 2015).

Domestic Abuse

There is increased potential for domestic abuse to escalate or start within a relationship during pregnancy. Early identification and intervention can reduce escalation and impacts on the parent-child relationship. A recent service impact review of the Barking and Dagenham Domestic Abuse service offer highlighted the wide range of services that are available to support people (mainly women) who are victims of domestic abuse, and the recent Commission commended the council on the leadership and wide-ranging support that is offered. However, there needs to be a greater focus on prevention and system wide approach through the new Place-based Partnership. There also needs to be clarity about what the overall outcome and impact measures are, to monitor progress of the work.

> "In short, failure to ensure that children are ready to learn not only robs them of their potential and squanders a vital national asset: it also reinforces inequality and obstructs social mobility".
> Save the Children, 2018

Mental Health

Poor parental mental health can have a large impact on the parent-child relationship and child development. Start for Life is currently funding a perinatal mental health support service for parents with low-moderate mental health distress, delivered by our partner MIND. This service is very popular, and outcomes are looking promising. We suggest that it would be sensible to consider the continuation of this service beyond the Start for Life grant period.

Opportunities to Address Issues Through the 0-19 Healthy Child Programme

Although not providing immediate impact, an area of focus to ensure our children and young people are healthy, is the 0-19 Healthy Child Programme.

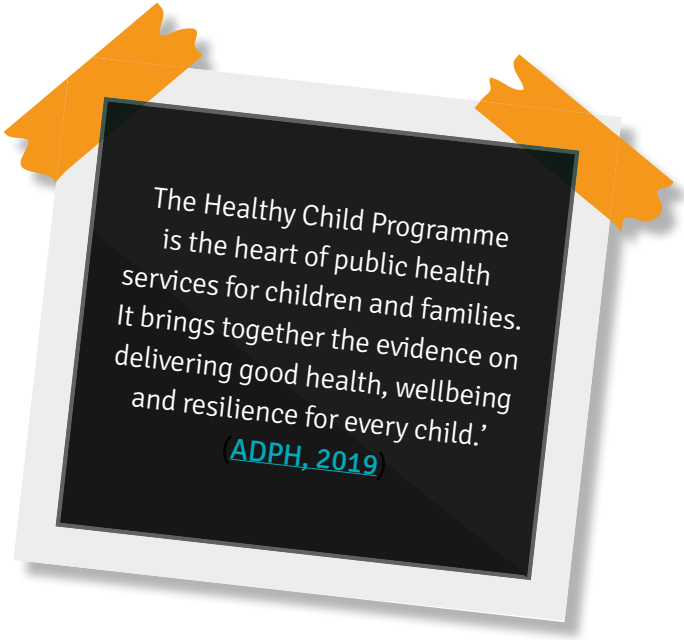
What is the 0-19 Healthy Child Programme?

The 0-19 Healthy Child Programme (HCP) service is a statutory service funded under the council's Public Health Grant, providing public health input for every child in the borough in the form of the Health Visiting (0-5 years), which includes the 5 mandated health assessment visits and School Nursing services and includes the mandated National Child Measurement Programme (NCMP) (5-19 years)[60]. The current provider of the integrated 0-19 Healthy Child Programme service is North East London Foundation Trust (NELFT).

The Department for Health released the latest 0-19 Healthy Child Programme Guidance in June 2023, updating the evidence base and aligning outcomes with the new Family Hubs programme. Barking and Dagenham made a successful bid for Start for Life and Family Hubs funding and has prioritised Family Hubs as the delivery model to achieve many of the outcomes in the Best Chance Strategy.

Key Opportunities

The evidence is clear, that a focus on key 'high impact areas' for 0-5 and 5-19 will maximise the outcomes achieved by this service. They are central to both delivery models, contributing to achievement of the Early Years aims (focusing on preconceptual care and continuity of care, reducing vulnerability and inequalities, improving resilience and promoting health literacy, and ensuring children are ready to learn at 2 and ready for school at 5) and the aims for school aged children and young people (reduce inequalities and risk, ensure readiness for school at 5 and for life from 11 to 24, support autonomy and independence, increase life chances and opportunity).



The 6 early years (0-5 years) high impact areas:

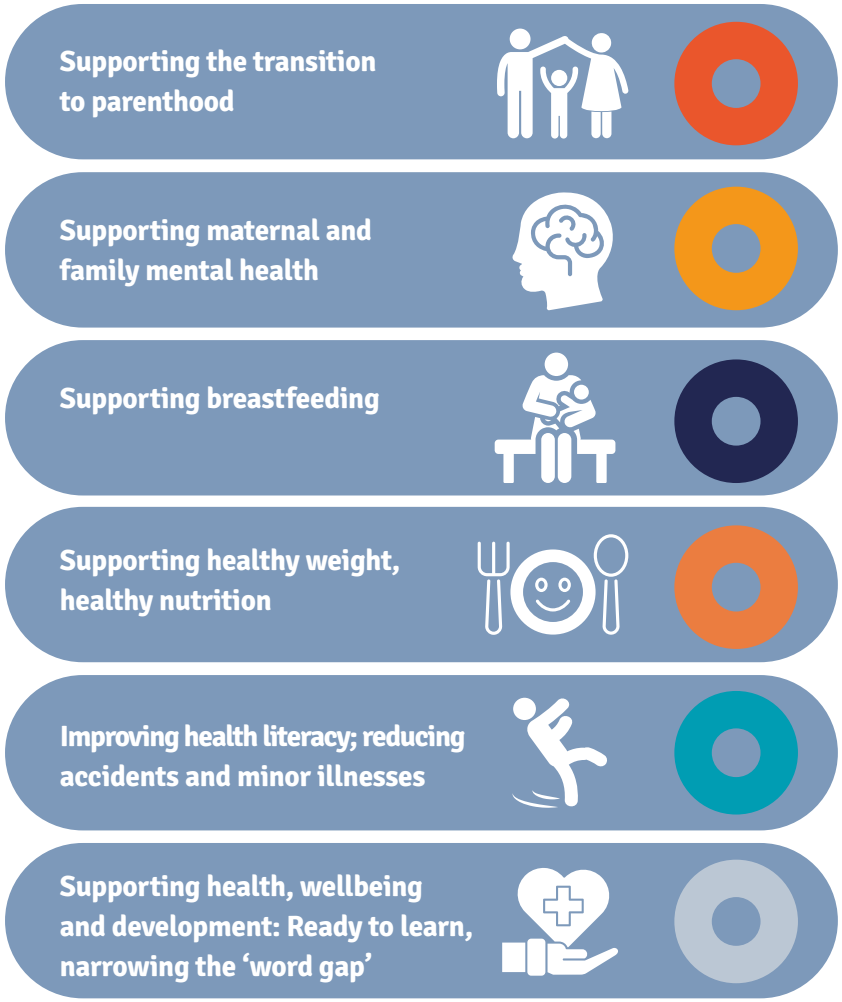


Figure 19: The high impact areas for early years

The 6 school age years (5-19) high impact areas:

Figure 20: The high impact areas for school age years

The 0-5 HCP Service provides a series of mandated visits to all children under 5 in the borough (see Figure 21) and is in a strong position to identify families who may need additional support, and either provide this themselves or connect them with services to prevent ACEs escalating and impacting on that child. They also provide an opportunity to identify signs of neglect and offer the support required.

Our data indicates a need for a stronger **universal offer** to support parents for the first 1001 days to ensure that more of our children are 'school ready' by the time they start school. Redesigning our current service will allow for us to align provision to needs and use the most up to date evidence and recommendations to improve our outcomes.

The 5-19 HCP service can work with the rest of the system, providing public health leadership, to help with prevention, earlier identification, and addressing of ACES, therefore reducing risk and impact of ACES, improving health and saving money. It can also support building resilience, raising awareness of behaviour norms and environments which contribute to ACEs, and developing trauma informed practice within communities and settings.

These **universal reviews** (in Figures 21 and 22) provide opportunity to support personalised or tailored interventions in response to individual or family need, using health visitors' and school nurses' specialist public health skills and clinical judgement to work with the child and family or young person to determine and address needs. They also work collaboratively with partners to deliver evidence-based interventions, protect children and keep them safe (PHE, 2021).

Figure 21: Universal health and wellbeing reviews and suggested contacts as part of overall support 0 to 5 years

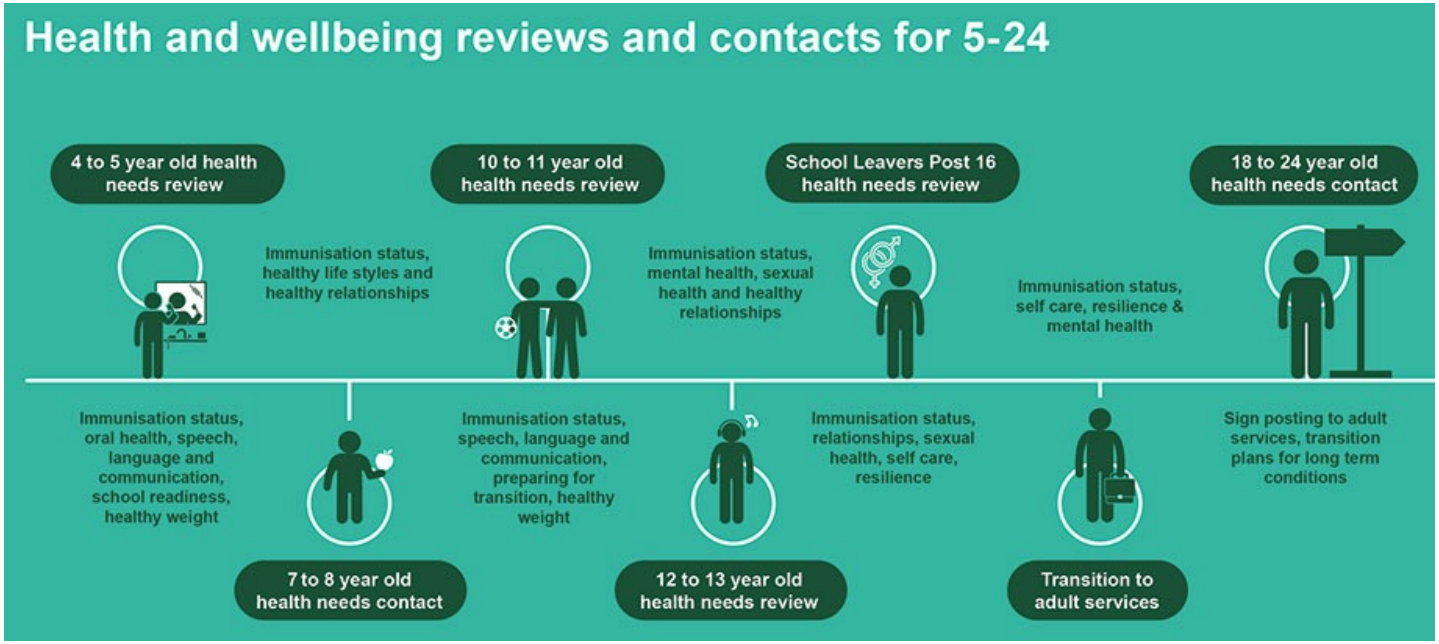


Figure 22: Universal health and wellbeing reviews and contacts as part of overall support 5 to 19, or 24

Prevention of ACEs

A redesigned 0-19 Healthy Child Programme would contribute to the following evidence-based approaches for preventing ACEs:

- Ensuring a strong start for children and paving the way for them to reach their full potential.
- Teaching skills to help parents and youth handle stress, manage emotions, and tackle everyday challenges.
- Connecting youth to caring adults and activities.
- Intervening to lessen immediate and long-term harms (Centres for Disease Control and Prevention, 2019).

Mental Well Being of Children and Young People

There remains significant need in the borough (and nationally) around mental wellbeing for children and young people. There is a clear role for School Nurses, as public health leaders, to advise schools and work with the wider system to support maximising the mental wellbeing of our children and young people. We suggest that the system needs to have increased focus on providing a better offer for those with social, emotional, and mental health needs, including timely access to CAMHS.

Our plans for the 0-19 Healthy Child Programme Service

Our 0-19 service is currently under review as it faces significant pressures of demand and the contract coming to an end provides a great opportunity to review the service, our needs and priorities, the evidence-base, the guidance, and the opportunities for change.

The following key challenges are impacting on our 0-19 HCP provision and will need considering in devising the new service contract:

- Increased population and **increased numbers of children under 19**.
- **Increased complexity of need** - including increase in special educational needs and disability (SEND), high domestic abuse, increases in safeguarding input required.
- **Lack of universal support for parents** - Children's Centres previously had a role in providing universal support but these are no longer funded across the borough, leaving a gap in this provision which is needed by many of our families.
- **Short term funding packages ending** - The Start for Life and Family Hubs programme (including the Early Help consortia) is currently providing universal support within the borough in parenting, infant feeding, perinatal mental health, 'home start', and home learning environment but this ends March 2025.
- **Workforce challenges** – national shortages and competition for staff with inner north east London boroughs makes recruitment challenging – a well skill-mixed 0-19 workforce would reduce these challenges by using staff to their maximum potential.
- **A siloed system** – There is a lot of silo working between services and families are struggling with 'falling through the cracks'. The family hubs programme is an opportunity for integrated working across the system to ensure that families find 'no wrong door' and only tell their story once to get the outcomes that they need. There is a clear opportunity for better links between the maternity system and the Health Visiting service.
- **High child poverty** (46% of households) Families who were already deprived are facing more challenges with life post-COVID and the cost of living crisis.
- **Poor school readiness and attainment** – COVID-19 has disrupted development for our youngest children: personal, social, and emotional development delayed in 44% of pupils nationally in 2022 - disadvantaged children and those with SEND are worst affected.
- **COVID-19:** Children born during the pandemic missed out on these crucial face to face contacts. Especially those due the 2-2.5yr review – delays were not picked up. No visits to spot early signs of risk or neglect. Increase in children not meeting a good level of development at 2-year checks;
- **Increase in cost of delivery** – meaning the current contract is underfunded even before considering the population increases;
- **Provider market** - Lack of alternative provider in the market and value on contract not attractive to other providers;
- Lack of funding for **specialist school nursing for Additional Resourced Provision** (ARPs) settings (which isn't funded by the NHS North East London) which is putting a strain on the school nursing service – the new service will have additional clarity on responsibilities and work is needed at a system level to ensure there is provision for ARPs;
- **High and increasing Obesity rates.**
- **Poor oral health** – there is a lack of oral health promotion provision in the borough, poor diets, and nationally there is insufficient NHS dentists to meet demand.

Public Health Advice

We need to strengthen our approach to giving children the best start in life, via universal support/prevention activities, early identification of emerging issues, and provision of timely help to support families. This can be achieved by maximising the opportunities of the 0-19 programme so it better links to the needs of the children and young people and the drivers of demands in Health and Social Care.

Therefore, the 0-19 programme needs to focus on the high impact areas of the Healthy Child Programme and address the causes of Adverse Childhood Experiences including neglect, to support our vulnerable children to thrive in their home and school environment.

Chapter 6:
Keeping our Residents Safe from Infectious Disease

Protecting residents from communicable diseases remains one of my core statutory responsibilities, with the public health system working together to manage and prevent serious notifiable diseases and outbreaks. The most important function is the containment of notifiable infectious diseases.

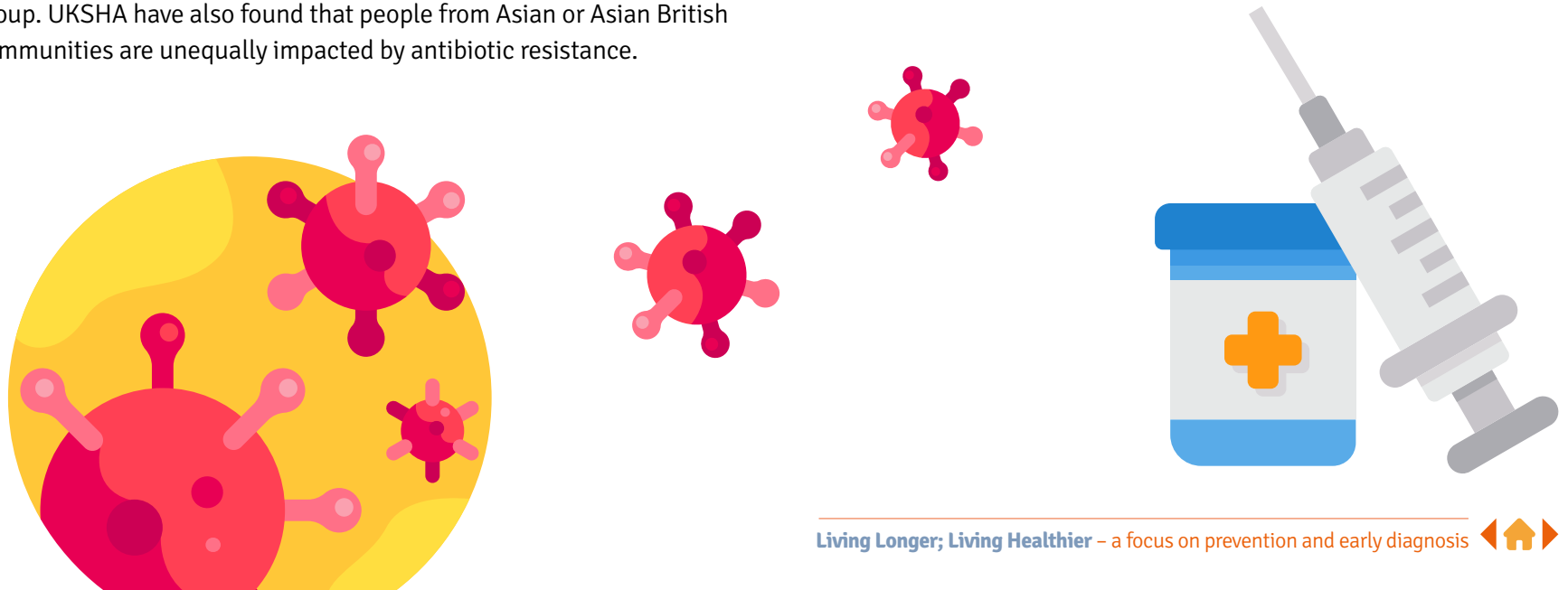
COVID-19 has changed the way we work on health protection issues today–for example we recognise the importance of all communities having access to vaccinations and we now seek to understand and address why people are hesitant to take up opportunities to protect their health. Furthermore, as was identified in the Public Health England report[61], people who have poorer health e.g. living with one or more long term condition, had less resilience and were more likely to become seriously unwell compared to others.

The latest analysis of national surveillance data on antibiotic resistant infection reported by UK Health Security Agency (UKSHA) at its recent conference also identified the stark inequalities in antibiotic resistance, with people in the lowest socio-economic group more likely to have a resistant infection compared to the highest group. UKSHA have also found that people from Asian or Asian British communities are unequally impacted by antibiotic resistance.

Vaccination & Immunisation

After clean water, vaccination is the most effective public health intervention in the world for saving lives and promoting good health, (UKHSA, 2014). The World Health Organisation (2023) states that vaccines reduce risks of getting a disease by working with your body's natural defences to build protection. This means that many hospitalisations and deaths could be prevented by immunisation in the short term. Immunisation doesn't just protect the individual, it also helps to protect families and the community, especially those who cannot be immunised for medical reasons. It is important to have high coverage rates in Barking and Dagenham to maintain herd immunity, which means a large part of the population of an area is immune to a specific disease.

Work in the borough continues to improve the immunisation uptake rates especially for those eligible, and from the vulnerable and underserved communities.



The following vaccines are offered in Barking and Dagenham and childhood immunisations are generally delivered in GP practices/ health centres, while Vaccination UK delivers the school-age immunisations in schools:

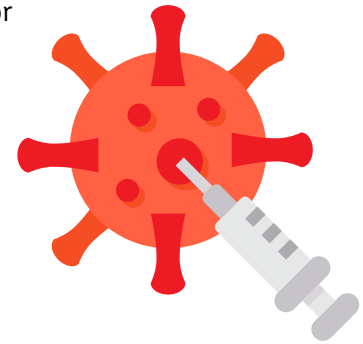
1. COVID-19 and Flu Vaccinations

These are offered to residents that are eligible at different seasons of the year. The offer is made via GP, community clinics, walk-in clinics, and community events. The seasonal booster uptake (2022/23) for older people was 65%, and frontline social care worker was 18%. Efforts to improve overall uptake are being made making more sites accessible, engagement activities, targeted messaging and communications, and a vaccination incentive programme within the care sector workforce.

2. School Aged Immunisations

School Age Immunisation Services providers are commissioned by NHS England - London (NHSE) to deliver the school-based immunisation programmes. Home schooled children and children not in mainstream schools for other reasons are also included. Vaccination UK are leading this programme and offering the following vaccinations in 2023/24: MMR, flu, HPV, two boosters to year 9s (DTP- Tetanus, diphtheria and polio, and Meningitis ACWY).

The public health team is supporting Vaccination UK and ensuring joint working and efforts with the schools, tailored communications, offering community clinics to also cater for homeschooling children, targeted clinics in areas with low vaccination uptake, and using the community organisations as levers to promote the programme.



3. Shingles Vaccination

Despite the seriousness of Shingles infection and the effectiveness of the vaccination to significantly reduce the chance of developing shingles, uptake rates of the vaccine are falling in London and across England. All eligible patients are offered the shingles vaccination by their GP as the practices are working to improve uptake all year-round following changes to the programme, from September 2023.

4. Polio

Following detections of polio virus in sewage samples in London in 2022, children aged 1-9 in London were offered an additional booster (or catch-up if not up to date) of the polio vaccine to ensure they were fully protected.

6. Measles Mumps and Rubella (MMR)

Measles is one of the world's most contagious diseases, spread by close or direct contact with an infected person via coughing or sneezing. One person infected by measles can infect nine out of 10 of their unvaccinated close contacts. Measles cases have been rising in London. There is no cure and vaccination is the only protection against becoming seriously unwell. Measles is one of the statutory notifiable infectious diseases.

The polio vaccination is offered in the MMR catch up programme and in April 2023, there were around 9,500 children aged 4-11 missing MMR or Polio in Barking and Dagenham. This equates to approximately, as reported by Together First: MMR Dose1 - 79%, and MMR Dose 2 - 67%. The World Health Organisation (WHO) recommends that an immunisation rate of 95% or more provides "herd immunity.

Vaccination UK started to deliver MMR catch-up campaign Phase 2 in August 2023 to the 4–11-year-old population, to ensure children are up to date with their childhood vaccinations, especially polio and MMR.

7. Chickenpox

The Joint Committee on Vaccination and Immunisation (JCVI) recommended in November 2023 that a universal varicella (chickenpox) vaccination programme should be introduced as part of the routine childhood schedule62. This should be a 2-dose programme offering vaccination at 12 and 18 months of age using the combined MMRV (measles, mumps, rubella and varicella) vaccine. It also recommended a catch-up programme should also be initiated following implementation of a programme to prevent a gap in immunity.

Why are Measles Vaccinations a Current Priority?

Background

Measles cases are rising in England this year. There were 128 cases between 1st January – 30th June 2023, of which the majority were in London, this is not expected to be higher. The vaccination rate is lower than the 95% target set by the WHO in areas of London, including Barking and Dagenham, in which 54% of 1–11-year-olds have received the full MMR vaccination dose as of September 2023[63].

Current Uptake of MMR in Barking and Dagenham

In 2021-22, only 67.8% of 5-year-old children in Barking and Dagenham had received 2 doses of the MMR vaccination. Of the 149 Local Authorities that submitted child vaccination data to NHS Digital that year, 143 had a higher second dose vaccination rate than Barking and Dagenham.

Analysis of our data shows a severe decline of our children receiving a first dose of the MMR vaccine at age 24 months, between 2013-14 and 2021-22, from 88.1% to 75.5%. This decline has occurred more rapidly in the borough than in London or England over the same period, highlighting the need for additional resource where available.

The decline in the first dose vaccination rate of children aged 5 years old has also declined between 2013-14 to 2021-22. However, the largest decline is seen in the percentage of 5-year-old children who have received a second dose of the MMR vaccine by the same age.

Inequalities in Uptake

NICE (2022) identifies the following population groups that are known to have low vaccine uptake or be at risk of low uptake:

- Some minority ethnic family backgrounds
- Gypsy, Roma and Traveller communities
- People with physical or learning disabilities
- Some religious communities (e.g., Orthodox Jewish)
- New migrants and asylum seekers
- Looked-after children and young people
- Children of young or lone parents
- Children from large families
- People who live in an area of high deprivation
- Babies or children who are hospitalised or have a chronic illness, and their siblings
- People not registered with a GP
- People from non-English-speaking families
- People who are homeless*

Many of these demographical characteristics can be seen within our population, so improving uptake needs more tailored approaches.

There are also several specific issues relating to our residents that we also need to consider:

- The transient population who moves around frequently and register at multiple practices without notification.
- Low vaccine acceptance in certain ethnic minorities.
- Despite being invited for vaccinations multiple times, parents/ carers are still not bringing their child(ren) in to get vaccinated.
- Different immunisation schedule for Eastern Europeans clashes with the UK immunisation programme.
- Language barriers.
- Fear of link of MMR to autism causing the vaccine hesitancy.
- Cultural differences (due to diverse make-up of our population).

The following analysis provides some indication of this:

Deprivation

Primary Care Networks (PCN) in areas with higher levels of deprivation have lower rates of unvaccinated children than the areas with low levels of deprivation. There are also large variations in levels of vaccination uptake by GP Practice, even within the same PCN.

The most recent data received from Together First in August 2023 from our General Practices showed:

Ethnicity

When grouped into the 5 major ethnic groups, shows there are significant differences across ethnic lines in the proportion of children who have received a full MMR dose (when looking at all children aged 1-11) see Figure 23.

Children whose ethnicity is listed as Other (i.e. ethnicity not disclosed) had the highest proportion yet to complete the full MMR vaccination course.

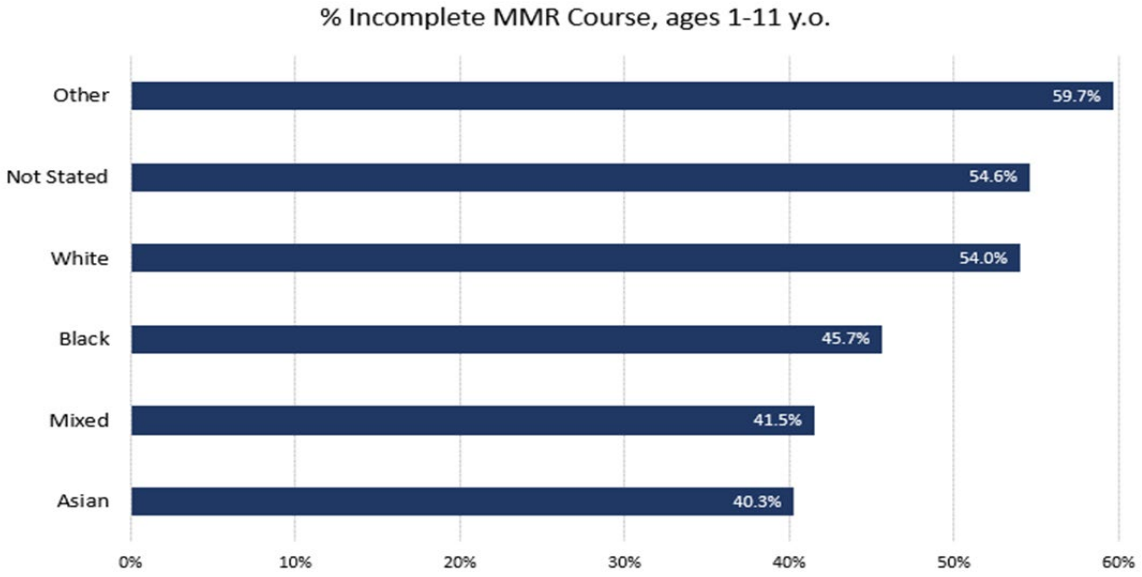


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Figure 23: Percentage of 1-11 year olds that haven't had a full MMR dose, by major ethnic group

When excluding the group that we do not have ethnicity information for (the Not Stated group), the next highest group is the White ethnic group, with 54.0% of White children aged 1-11 having not received a full MMR vaccination course.

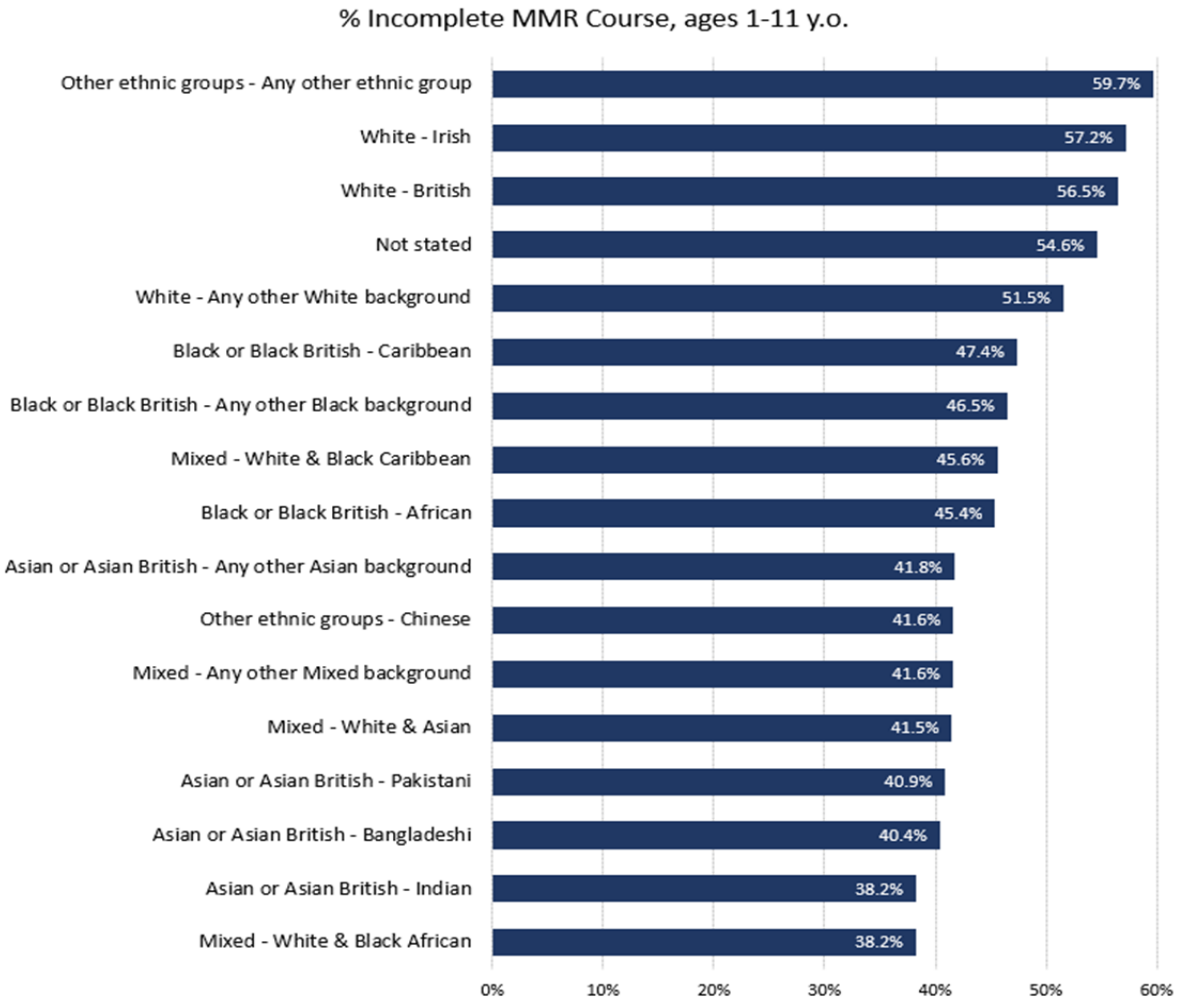


Figure 24: Percentage of 1- 11 year olds that haven't had a full dose of MMR, by specific ethnic group

This is reinforced in Figure 24 which shows that, after excluding the Not Stated group, 3 of the 4 ethnic subgroups with the highest proportion of incomplete full MMR courses were White. Those being the White – Irish (57.2%), White British (56.5%) and White – Any other background (51.5%) subgroups. Three of the next four highest groups are the 3 groups that combine to form the Black ethnic group: the Black or Black British – Caribbean (47.4%), the Black or Black British – Any other Black background (46.5%) and the Black or Black British – African (45.5%) subgroups. The gap between the highest and lowest groups in the borough is also quite high, at 21.5%, which is the difference between the Other ethnic group and the Mixed – White and Black African group.

There are also differences in incomplete vaccination proportions within ethnic groups at different ages. In particular, the 7 and 8-year-old age groups appear to be much less likely to have received a full course of vaccination than younger children of the same ethnicity in the White, Black, Asian and Not Stated groups.

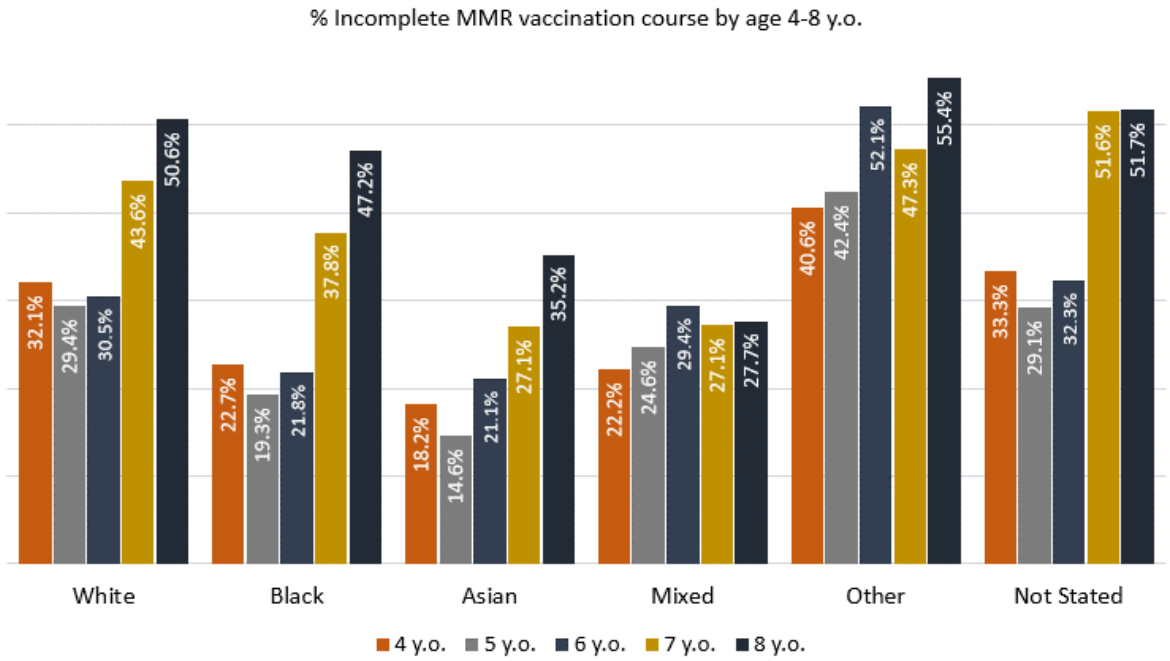


Figure 25: Percentage of 4–8-year-olds that haven't had a full dose of MMR, by major ethnic group

Action to Improve MMR Uptake in the Borough

Our plans are led through a partnership between the NHS, the council, and Vaccination UK, and have adopted the following UKHSA Risk Assessment recommendations[64] within our plans:

1. Assess population susceptibility to measles in all birth cohorts.
2. Improve MMR coverage to achieve 95% with 2 doses by time children are 5 years.
3. Urgent need for catch-up action for:
    - Children under-5 nationally
    - Children, teenagers and young people in London

Our plans also recognise the barriers identified by The Royal Society of Public Health[65] as accessibility and convenience of vaccination services and factors include timing of appointment and availability of appointments.

Plans are underpinned by Public Health England and NHS England (2020)[66] which recommended six areas of focus proven to optimise uptake of immunisations:

1. Strong leadership

2. Proactive promotion

3. Maintain accurate information

4. Effective call/recall

5. Maximise access and continuity

6. Trained and knowledgeable workforce

There were also lessons learnt from the COVID vaccine (NHSE, 2023):

- Lack of trust in government institution.
- Lack of trust in information.
- Belief that cost outweighs benefits, i.e., needing to inconvenience oneself. e.g., taking time off work to recover from the vaccine and its side-effects can lead to a reluctance to uptake.

And the following are recommended to overcome some of these challenges:

- Text messaging (information made available in relevant languages and proactively working to improve trust and relationships with patients).
- Community engagement.

The **MMR Action Group** commenced in August 2023 to improve vaccination MMR coverage with a target of 90%.

The following actions are taking place, adopted from NICE guidance, for areas with low vaccine uptake:

- Consider introducing targeted interventions to overcome identified local barriers and address identified inequalities in vaccine uptake between different population groups.
- Involve people in the local community when identifying barriers.
- Tailor service opening hours and locations for vaccinations to meet local needs.
- Provide a range of accessible options for booking appointments, consider using sites outside healthcare settings such as community and family hubs, or faith centres.
- The use of targeted messaging and community engagement. This will help to proactively improve trust and relationships with patients.

Examples of Specific Action

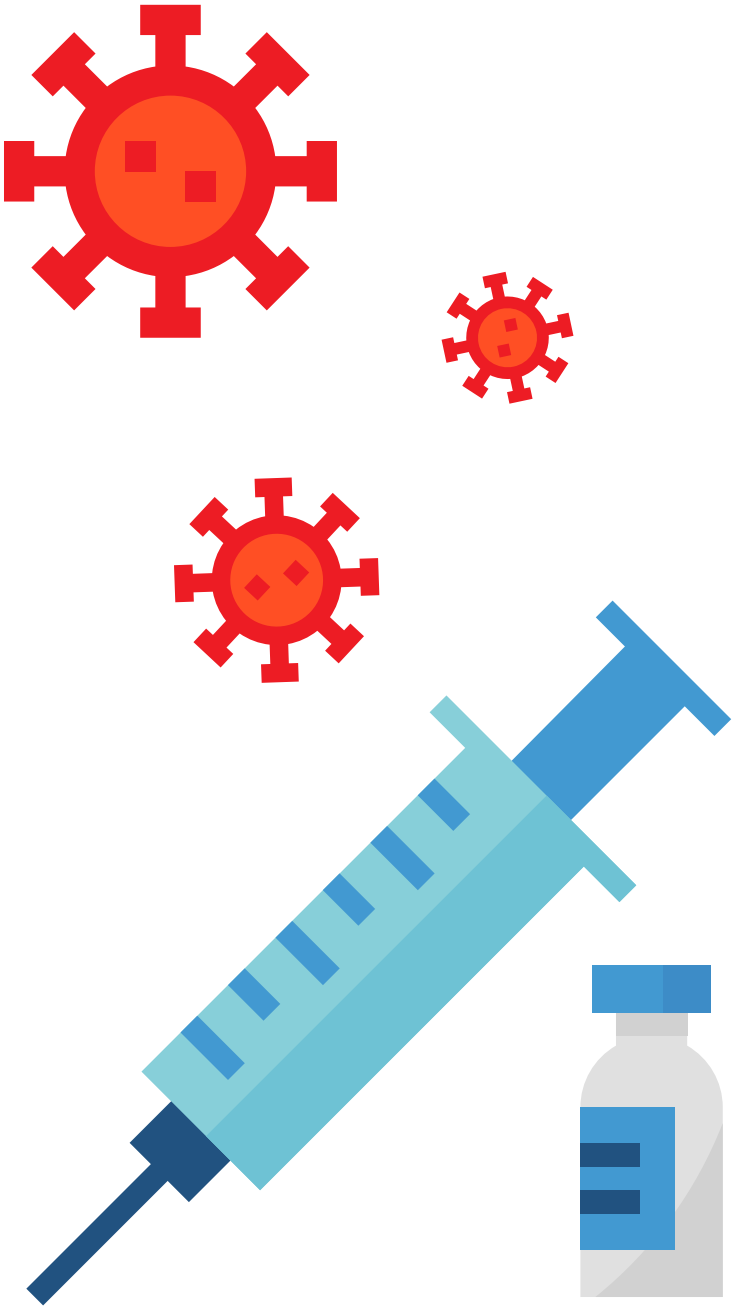
Together First has:

- Conducted Practice meetings with 27 out of 33 GP practices to better understand poor uptake and provide extra support where needed to help increase uptake rates.
- Set up a dedicated inbound booking line for parents/carers of registered patients and this has been extended to include outbound calls.
- Agreed with PCN East One about running a pilot to offer a 'full delivery' service option, where the team provide call handlers with a targeted list of parents/carers to contact and book in for MMR immunisations into the Enhanced clinics offered at the weekends to help working parents/carers.

Vaccination UK has delivered community clinics across all areas - 50 clinics being held in August 2023, mostly in libraries. Outreach clinics are also in the community hubs are being planned along with increasing extended hours at the GP practices.

Taking all this into consideration, a programme of action has been developed across Barking and Dagenham place partners to address the above lessons/challenges, with eight targeted workstreams:

1. **Phase 2 MMR Campaign led by Vaccination UK:** (catch-up school programme for over 5-year-olds) focuses on under-vaccinated children who are least protected and at the highest risk of becoming seriously unwell with polio as well as other preventable disease such as measles. Vaccinations will be given at the selected schools with the highest numbers of unvaccinated children. All primary schools will be supporting in facilitating a school-centric awareness programme for these children and helping to raise awareness of the importance of routine childhood vaccinations. Three levels of approach: 1) Schools: targeting the top 20 schools in the area that have the most children without MMR 2) GPs: targeting the top 20 GP's that have the most children short of MMR/polio scheduled Immunisation. 3) Community clinics to catch up during school breaks or after school sessions.
2. **Family and community hubs:** outreach work (including pop up clinics) at our family and community hubs to address vaccination hesitancy, promote benefits and to administer MMR vaccinations. Joint working with Vaccination UK in the delivery of community pop-up clinics in the wards that have the lowest vaccination rates.
3. **Targeted communications and messaging:** an integrated campaign using a two-pronged approach of targeted and broad-brush borough awareness raising activity to encourage vaccine uptake in the lead up and at the start of the new school year.



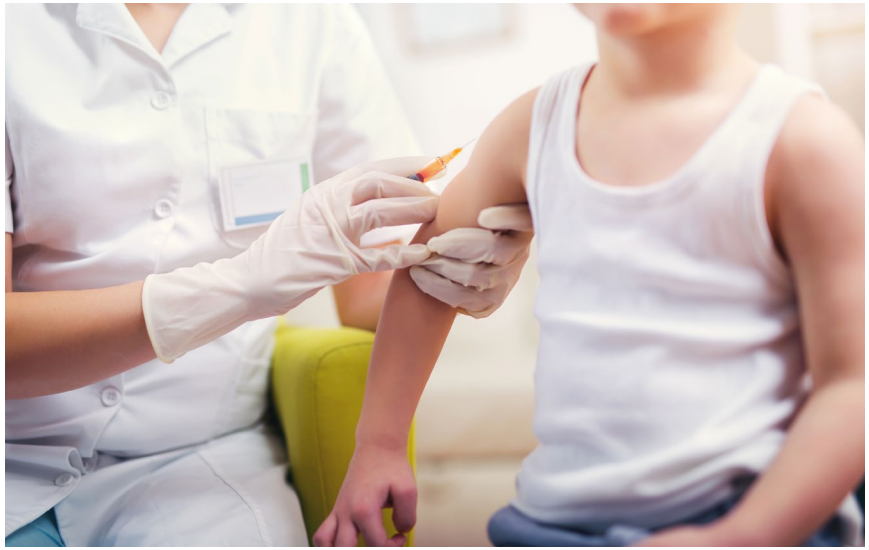
4. **Early years:** establish how to triangulate health visiting, GPs, and early years providers to improve take up, supported by GP Fed with additional enhanced clinics, for 0–5-year-olds. Training professionals and staff working in services in contact with families and young children, to ensure they have conversations to address vaccine hesitancy and to signpost families to the community clinics. These staff have a trusted relationship with the families, and this would encourage them to make every contact count.

5. **Engagement work with Eastern European communities:** (through our voluntary, community and faith partners) to provide additional support to practices and extra time for families who are vaccine hesitant to discuss their concerns with a health professional, through an interpreter where needed. An Eastern European organisation will work with public health for six months with the proposed activities for the MMR awareness outreach: venue/org mapping and ongoing engagement; leafleting; Barking food bank drop-ins; digital engagement; content resharing; online live events with a medical professional.

6. **Engagement work with faith groups:** links have been made with Black and African organisations/churches to engage with their community and address vaccine hesitancy. These will be levers and channels to promote the communications messaging and promote community clinics in the borough.

7. **Outreach work with refugee and asylum seekers:** dedicated health and wellbeing events for residents from migrant communities, delivered by local and community-based providers who specialise in providing holistic support for asylum seekers, refugees, and immigrants. Public health will promote MMR in the four hostels in the borough and include this cohort in the community pop-up events.

8. **Co-production:** partnership working with all key stakeholders, health, council and voluntary sector in the design and development of the plans. Effective data sharing arrangements with health and Vaccination UK, to ensure the effective continuity of the service delivery to the families.



Public Health Advice

We need:

- Our Place Based Partnership to prioritise childhood immunisation to improve and reduce the differences of uptake within our communities.
- Sustain investment to improve the uptake of vaccinations especially MMR, reduce the inequity of uptake and to introduce the chickenpox vaccination if directed, following recommendations of the Joint Committee of Vaccinations and Immunisations.
- Communications strategies that are simple and hard-hitting, with continuous messaging on the importance and benefits of vaccination.

Acknowledgements

I'd like to thank the following members of my team for their contributions to this report:

- Bianca Hossain
- Carol Matenga
- Jane Leaman
- Jess Waithe
- Mike Brannan
- Neha Shah
- Pauline Starkey
- Rebecca Nunn
- Richard Johnston
- Sophie Keenleyside

References

References

To find out more information on our strategies, policies and plans click here.

Barking & Dagenham

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North East London Health & Care Partnership

Committees in Common of and Health Wellbeing Board and ICB Sub-Committee

16 January 2024

Title of report	Barking and Dagenham Partnership Risk Register
Author	Sharon Morrow, Director of Partnership, Impact and Delivery
Presented/Sponsored by	Sharon Morrow, Director of Partnership, Impact and Delivery
Contact for further information	Sharon Morrow, Director of Partnership, Impact and Delivery Sharon.morrow2@nhs.net
Wards affected	All
Key Decision	No
Executive summary	The paper presents the partnership risk register which captures the risks to meeting the partnership strategic objectives. This includes risks that have been identified in respect of partnership priorities for 2023/24 and will be updated as plans are refreshed for 2024/25. Current risks include: • the capacity in our management and clinical teams and the impact that this may have on delivery • capacity in children and young peoples' therapy services to meet the increasing demand for children and young people with SEND • the current High Intensity Service across BHR is not adequately supporting Barking and Dagenham residents who meet the criteria for the service • the current model for proactive care does not meet best practice guidance and a there is not a case finding tool in place The register is under development and will be updated by the partnership delivery groups.
Action / recommendation	To consider, note and propose any changes to the risk register.
Reasons	It is good governance to develop a risk register that enables risks to the achievement of our objectives to be recorded and proactively managed
Previous reporting	Barking and Dagenham Executive Group
Next steps/ onward reporting	For monthly review by the Executive Group

Conflicts of interest	There are no conflicts of interest in relation to this report
Strategic fit	The Place risk register forms part of a risk management framework for the ICB and supports achievement of the ICB's corporate objectives through managing risks to delivery. It relates to all ICS aims: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The paper sets out key risks for the partnership to achieve our aims for the health and wellbeing of our population.
Impact on finance, performance and quality	Related to performance and quality.
Risks	This report relates specifically to risk and ensuring a joined-up approach to the management and oversight of risks in Barking and Dagenham.

1.0 Purpose

The purpose of the paper is to present the partnership risk register. This is based on the NHS NEL risk register template and supports the ICB risk management process.

2.0 Background

2.1 It is good governance to develop a risk register that enables risks to the achievement of our objectives to be recorded and proactively managed.

2.2 The main purpose of the risk register is:

- to achieve greater visibility of threats that may prevent the B&D Partnership from achieving its objectives
- to create a record of the identification and control of key risks
- to respond more effectively when potential risks occur and to move towards more pro-active, rather than reactive, management
- to further develop the integrated approach to risk management, whether the risk relates to clinical, non-clinical, financial or organisational risk
- to escalate risks where a wider system response is required

2.3 The partnership risk register is not intended to replace organisational risk registers, where operational risks to delivery are managed, and focuses primarily on areas that require a multi-agency response in order to mitigate risks in Barking and Dagenham.

2.4 The partnership is in the process of agreeing its key priorities for 2024/25 with delivery plans, and supporting governance under review. It is expected that the risk register will be updated by the partnership delivery groups with assurance through the Executive Group. Key risks will be reported to the Committees in Common.

3.0 Risks on the register

3.1 The current risks, along with updated scores are as follows, with the detail included in the appendix:

- A lack of programme capacity at place will impact on our ability to deliver on key objectives and accountabilities which will result in potential reputational damage to the ICB and the Place Partnership and disengagement of partners.

- If there is a reduction in clinical and care professional leadership (CCPL) at place, this could lead to poor decision making, services being developed without proper clinical involvement and could ultimately result in poor outcomes for residents.

- The capacity in CYP therapy services is insufficient to meet the increasing demand for CYP with SEND, which is growing faster that GLA predictions. This will result in poor health outcomes for our CYP, increased health inequalities, increased cost of long-term care and inability to retain staff managing high caseloads.

- A review of the High Intensity Service across BHR has identified that the current service is not adequately supporting Barking and Dagenham residents who meet the criteria for the service

- Barking and Dagenham Place does not currently have a consistent proactive care model across all practices as detailed by NHS England Guidance. A case finding tool should be in place to support proactive case finding of residents requiring coordinated care, there is currently no tool in place in Barking and Dagenham

4.0 Process for escalation

4.1 Risks that are rated 15 or above should be considered for escalation to the Committees in Common and Chief Officer portfolio register, if there isn't an adequate plan to mitigate risks at place level.

5.0 Attachments

- Appendix 1 - Partnership risk register December 2023

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ID no.	Date raised	Area Raised by	Initial risk score	Corporate objective	Risk description	Previous rating	Current rating			Target rating	Target completion date	Completed mitigating actions	Mitigating actions in progress	Risk owner	Action Owner	Responsible committee	Escalation required (Y/N)	Escalation Details	Updates/ comments	Close Down Status
							Likelihood	Impact	Risk Score (1-25)											
BD001	1.12.23.	Director of Partnership, Impact and delivery	15	To support outcomes in population health and healthcare	A lack of programme capacity at place will impact on our ability to deliver on key objectives and accountabilities which will result in potential reputational damage to the ICB and the Place Partnership and disengagement of partners.	New	3	4	12	8	30.3.23.	A place structure has been agreed, although some efficiencies are required. Some recruitment to vacant posts has been completed through staff being slotted in and recruitment to priority posts. Recruitment o remaing posts has started.	ICB working with LBBD to explore the development of a joint structure that aligns our teams to strengthen the commissioning team capacity to respond to our business priorities.	Sharon Morrow	Sharon Morrow	Executive Group	No	Added to the CPPO risk register		
BD002	1.12.23.	Executive Group	12	To support outcomes in population health and healthcare	If there is a reduction in clinical and care professional leadership (CCPL) at place, this could lead to poor decision making, services being developed without proper clinical involement and could ultimately result in poor outcomes for residents.	New	4	3	12	9	30.3.23.	ICB agreement to delay the reductions to April 2024 in order to ensure we have time to review the current structure and make an informed decision. B&D proposal drawn up that enables the resource to be flexed across priority areas. NELFT have agreed to fund 1 session/week for the mental health CPPL.	NEL ICB has convened a system-wide group to consider how to make the most of the CCPL workforce across the system.	Rami Hara	Rami Hara	Executive Group	No	Added to the CPPO risk register		
BD003	1.12.23.	SEND Area Board	16	To support outcomes in population health and healthcare	The capacity in CYP therapy services is insufficient to meet the increasing demand for CYP with SEND, which is growing faster that GLA predictions. This will results in poor health outcomes for our CYP, increased health inequalities, increased cost of long-term care and inability to retain staff managing high caseloads.	New	4	4	16	8	30.6.23.	A business case for additional therapy capacity was endorsed by the CiC on 7.11.23. The ICB has agreed non-recurrent funding of up to 98K in 23/24. NELFT have agreed to recruit at risk.	Business case to be resubmitted in the 24/25 planning round for recurrent funding.	Sharon Morrow/ Melody Williams	Ronan Fox/ Mohammad Mohit	SEND Area Board	No			
BD004	3.01.2024	Deputy Director Lead for Ageing Well	12	To support outcomes in population health and healthcare	A review of the High Intensity Service across BHR has identified that the current service is not adequality supporting Barking and Dagenham residents who meet the criteria for the service	New	3	4	12	8	TBC	Review of current service undertaken to understand the challenges and issues. Best practice explored looking at services in other boroughs	Task and finish group being set up to develop a new model for 2024/25	Kelvin Hankins	Kelvin Hankins	Adults Group	No			
BD005	3.01.2024	Deputy Director Lead for Ageing Well	16	To support outcomes in population health and healthcare and tackling health inequalities	Barking and Dagenham Place does not currently have a consistent proactive care model across all practices as detailed by NHS England Guidance. As per national guidance a case finding tool should also be in place to support proactive case finding of residents requiring coordinated care, there is currently no tool in place in Barking and Dagenham.	New	4	4	16	8	tbc	Pilot agreed for 1 PCN for a proactive and case finding model	Evaluation of pilot and development of a roll out plan for the proactive care model.	Kelvin Hankins	Kelvin Hankins	Adults Group	No			

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