Barking & Dagenham: Ageing Well (draft)

North East London Health & Care Partnership

The benefits that Barking and Dagenham residents who require proactive care will experience by April 2024 and April 2029:

- April 2024:
  - Greater access to wider activities in communities to improve health & well being
  - Fewer exacerbations of ill health and a better quality of life
  - Some new models of care that have been co-designed with residents
- April 2029:
  - Fewer residents moving from moderate to severe frailty
  - A reduction in non-elective activity due to chronic ambulatory care sensitive conditions
  - Providing services and support for residents to prevent development of health conditions and understand when and how to access services for the assessment and management of long-term conditions.
  - Improving health and wellbeing for residents, particularly those with long term conditions

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

- By addressing the impact of the wider determinants if health in the development of the model of care
- By building trust with residents, connecting them to community support, and engaging the voluntary sector and residents in co-designing services around residents
- By delivering a better resident experience by ensuring residents receive integrated and personalised health in places they choose to access, resulting in a better quality of life
- By reducing avoidable exacerbation of physical and mental ill health, including in underserved groups.

Key programme features and milestones:

To develop a new model of care across health, care and the voluntary sector that supports individuals in achieving their biopsychosocial and clinical goals. Programme objectives are:

- To develop an MDT approach for people with mild/moderate frailty and co-morbidities (Q3 23/24)
- To connect disjointed parts of the system together by integrating PCNs with the VCSE through and emerging locality leads model (Q2 23/24)
- To establish a high intensity user service that meets best practice guidance, focussing help for non-medical factors as well as poor physical & mental health (Q3 23/24)
- To support carers identification training and carers support in line with the actions outlined within the Carers Charter (Q1 23/24)

Further transformation to be planned in this area:

- Over the next two years
  - Accelerate integrated care delivery at neighbourhood and place by using PHM to drive tangible change
  - Review the social prescribing model to optimise impact and integration with VCSE
  - Develop greater use of technology to support people living at home
  - Ensuring more residents with health conditions are assessed, identified and provided with condition management as early as possible.
- Over years three to five
  - Explore opportunities for integrating community hubs into the model
  - Providing support to enable independent living
  - Strengthening the NHS response to identifying and addressing domestic abuse

Leadership and governance arrangements:

- B&D Adults Delivery Group
- B&D Executive Steering Group

Key delivery risks currently being mitigated:

- Programme resource not yet aligned to delivery plan – this has been included in ICB restructure; interim project capacity being explored
- Analytics support for PHM and data sharing agreements to be agreed
- PCN engagement and capacity to expand MDT working:

Programme funding:

- Ageing Well funding TBC (network roles)
- Health inequalities funding (localities model)
- Business case to be developed for HIU service

Alignment to the integrated care strategy:

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

Barking & Dagenham: Best Chance for Babies, Children and Young People (Draft)

North East London Health & Care Partnership

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Barking & Dagenham: Healthier weight (Draft)

North East London Health & Care Partnership

Healthier weight / London Borough of Barking and Dagenham Public Health / Dr Mike Brannan Mike.Brannan@lbbd.gov.uk

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

- April 2024:
  - Weight management services more tailored to needs and preferences of families
  - Improving coordination and coherence across workstreams and stakeholders
  - Development of a Tier 3 Weight Management Service pilot
- April 2028:
  - Integrated approach to healthier weight services appropriate and accessible to residents
  - Greater promotion and access to healthier weight opportunities (e.g. activity, healthy diet)

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

- By ensuring those with an unhealthy weight are able to access support through weight management services that meet their needs and preferences
- By supporting and enabling more residents to consume a healthier diet (~1 in 2 adult residents not achieving '5 a day'; lowest in London)
- By supporting and enabling more residents to (~1 in 2 adult residents not active enough for good health; second highest in London)
- By creating environments and opportunities to make healthy eating and regular physical activity the easy choice.

Key programme features and milestones:

Healthier weight requires action across the drivers of weight and their determinants, therefore work covers:

- *Assessment and weight awareness raising* - National Child Measurement Programme
- *Weight management services* - Tier 2 (0-5, 5-12, Adults), Tier 3 pilot (CYP; FY2023-25), CVD Prevention, NHS Digital weight management, Diabetes Prevention
- *Physical activity promotion* – Community programmes, Sport and leisure services, park services, Exercise on referral, School Games, Social Prescribing
- *Healthy diet promotion* – Food Education Partnership, Good Food Economy Action Plan
- *Healthier lifestyles* – Healthy schools programme, 0-19 Universal services, Holiday Activity & Food clubs, Eat Well, Live Well, Feel Great (SEND)

Further transformation to be planned in this area:

- Over the next two years
  - Expansion of whole systems approach across wider stakeholders
  - Better targeted/tailored and more integrated weight management services
- Over years three to five
  - Coherent approach to promoting healthier weight behaviours (activity, diet)

Programme funding:

- LBBD (Public Health Grant, Education)
- NEL ICB

Leadership and governance arrangements:

- NCMP working Group
- BHR Health and Care Cabinet
- Whole Systems Approach to obesity working groups

Key delivery risks currently being mitigated:

- *Lack of coordination* – Creation of collaborative working (e.g. NCMP working group) and cross promotion
- *Commercial determinants / obesogenic environment* – Creating healthier food and activity environments and opportunities
- *Wider societal drivers (e.g. deprivation)* – Embed promotion and support for healthier weight behaviours across Place interventions

Alignment to the integrated care strategy:

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

Barking & Dagenham : Stop Smoking&Tobacco Control (Draft)

North East London Health & Care Partnership

[Stop Smoking service (specialist and pharmacies] / [part of the system is leading on delivery] / [SRO and email address]

The benefits that Barking and Dagenham's residents will experience by April [2024] and April [2026]:

- April 2024:
  - Improve recording of ethnicity data to ensure more accurate data on smokers
  - Increase number of quitters year on, particularly in BAME men
  - Reduction in rates in women, minimise proliferation of Shisha outlets & illegal tobacco sales
  - Reduction in vaping and shisha use in young people
- April 2026:
  - Reduction in smoking attributable hospital admissions and mortality
  - Accessible evidence-based stop smoking services

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

- By 2024, increase access to smokers from all communities including BAME and males who have a higher smoking prevalence.
- By 2025 reduce smoking in women, especially in pregnancy hence improve the child's best start to life.

Key program features and milestones:
LBBD has an inhouse service delivered by Comsol:
Level 3 specialist stop smoking service. Target groups
• COPD patients
• Pregnant women and partners
• Patients with diagnosed mental health condition.
• Young smokers aged 12-15
• Routine and manual workers.
The service offers holistic support to residents addressing the wider determinants, behavioural support and pharmacotherapy. Training for pharmacies. Working with the targeted lung screening programme to reach more males.
Level 1: London digital smoking service.
Trading Standards Team work on illicit tobacco & shisha use.

Further transformation to be planned in this area:
- Over the next two years
  - Work with schools to implement NICE guidance on School-based interventions for preventing smoking.
  - Joined up working approach with Trading Standards.
- Over years three to five:
  - Deliver system wide approach to improve access by exploiting place-based arrangements e.g. provision of services in community venues .e.g. faith groups.

Programme funding:
- Overall sum and source: £400k
- Breakdown across capital, workforce / care services, programme delivery:
- Workforce £206k/programme delivery 194k

Leadership and governance arrangements:
- Director of Public Health
- Director of Community Participation & Prevention
- NEL NHS Tobacco Treatment Program Steering Group

Key delivery risks currently being mitigated:
- Service provision: review of the effectiveness of Comsol and service outcomes.

Alignment to the integrated care strategy:

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

Barking & Dagenham: Estates (draft)

North East London Health & Care Partnership

The benefits that Barking and Dagenham residents who require proactive care will experience by April 2024 and April 2026:

- April 2024:
  - Improved access to a wider range of community diagnostics
  - Better access to primary and community care service through the Beam Park Health Centre
- April 2026:
  - Access to one stop shops for health and care through integrated hubs in the community
  - Access to an integrated community, leisure and health hub for residents in the Barking Riverside area; improved access to primary

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

- By improving access to services closer to home
- By increasing capacity for more flexible, integrated service provision which enables care co-ordination and multi-disciplinary working across health, care and the VCSE
- By delivering a better resident experience through person centred estate that meets the needs of local communities

Key programme features and milestones:

To develop Barking and Dagenham infrastructure plan that will enable the partnership to deliver levels and quality of health and wellbeing services from sufficiently located, sized, and equipped premises in the short, medium and longer term as the population grows. The programme includes:

- The development of a SOC for Barking Community Hospital and Town Centre
- The development of the Barking Riverside hub business case (NHS lease agreement Q3 23/24)
- Optimisation of Beam Park health centre estate (open spring 2024)
- Mobilisation of the new Community Diagnostic centre (Q3 23/24)

Further transformation to be planned in this area:

- Over the next two years
  - Procurement of the health centre at Barking Riverside
  - Infrastructure development to support neighbourhood networks/Fuller implementation
- Over years three to five
- Public sector partners will develop their roles as an anchor institution.
- Deliver the Serious Violence duty to reduce child exploitation and crime

Programme funding:

- NHS capital funding
- Section 106 funding for health infrastructure

Leadership and governance arrangements:

- B&D Local Infrastructure Forum
- B&D Partnership Board

Key delivery risks currently being mitigated:

- There is insufficient internal resources to deliver the programme - business case for interim capacity to be developed
- Service models can't be agreed – ensure early involvement of clinical teams in the development
- Revenue to support new healthcare estate – work with the LA Regeneration and Planning teams to maximise the S106 contributions for health infrastructure

Alignment to the integrated care strategy:

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

Standard template: transformation in NEL

Cardiology in BHR Places(HFrEF & HFpEF)– SRO: Jeremy Kidd

North East London Health & Care

The benefits that Barking, Havering and Redbridge residents will experience by April 2024 and 2029:

By 2024

- Reducing variation in practice for people with **heart failure**, improving care and outcomes for patients who access acute, community and primary care
- Delivering good links via integration between community and acute via multidisciplinary team (**MDT**) meetings
- Improve **cardiac rehabilitation (CR)** to include cancer pre-rehabilitation and pulmonary rehabilitation
- Strengthen **health psychology** offer to reflect multimorbidity
- Explore, develop and scale up **Heart failure@Home**
- Strengthen the **Cardiac Prevention Pathway** through behaviour change communications which will encourage people to seek advice/promote the importance of risk factor management

By 2029

- All patients with with suspected heart failure and NT-proBNP >400 ng/l will receive urgent referral for specialist assessment and echocardiography at Place
- All patients with advanced heart failures will receive Heart Failure Specialist advice or review
- Improved psychological wellbeing of patients with heart failure will increase healthy longevity, improving quality of life, preserving good mental health and cognitive function, and achieving health care savings on individual &system level.
- More people managed from the comfort of their home and improving virtual care
- Increasing number of patients will be able to self-manage their conditions

How this transformation programme reduces inequalities between BHR Places residents and communities:

- Through service standardisation- single point of access, standardised clinical management pathways across BHR Places, discharge process and information to primary care, access to advanced medications across BHR, referral criteria, use of patient literature and patient information sheet.
- HFrEF scheme will impact on these improvement areas: reduce waiting times, possible development of PHP, expansion of MDT to include renal and palliative care, additional training on EOL, UCP and relationship building with specialist palliative teams and promote education and self-care, and exercise programme
- The schemes will improve greater access to community interventions, digital solutions and health literacy support tailored to at-risk groups
- CR is part of a multilevel approach addressing barriers related to healthcare system access and improving provision, referral and participation in high risk groups

Key programme features and milestones:

- Establish Governance for 2023-24 and forward, including linkage to Place. Reporting at “End -to-End Pathways Working Group (COCWP) ongoing
- HFrEF Phase 2:
  - Review Phase 1 (Q1 23/24)
  - Ensure maximum utilisation of existing HFrEF service (from Q2 to Q4 2023/24);
  - Ensure that the service is using efficient and effective systems and technology to deliver the service
  - Ensure standard access to other services including; Dietetics/ NHS Psychological Therapies Service (IAPT)/ Health Psychology/ End of life-Co-ordinate My Care (CMC)/ Hospice/ Expert Patient Programmes (EPP) (Q1 23/24)
- HFrEF Phase 3:
  - Enhance and expand in business case HFrEF service
  - Create an innovative service that can respond and adapt to the changing needs of the local health economy (digital technology, NHS@Home)
- Business case for HFpEP in Q4 23/24
- Standardise community cardiac service with integration with acute-WX, BHRUT

Further transformation to be planned in this area:

- Over the next two to five years
  - ➢ Business case to stand up cardiac rehabilitation service for heart failure patients across BHR Places in community
  - ➢ Scoping opportunities for streamlining access to cardiac diagnostics/ ancillary for care

Programme funding:

Current cost of HFrEF

- £750K

Estimated cost of HFpEF

- Yet to be determined (Source= unknown)

Leadership and governance arrangements:

- Level 1: Place based Partnership
- Level 2: LTC Board (or architype/successor)
- Level 3: NEL Cardiac Clinical Network

Success will depend on Collaboratives with BHRUT/NELFT; Place is a crucial determinant and NEL Business case process.

Given the increasing multimorbidity of LTCs, a cardiometabolic approach to risk and commitment to end-to-end pathways is important. Not viewing cardiac pathways in silos but understanding close links with Diabetes, Respiratory and CKD. Prevention including LA schemes directed at upstream.

Key delivery risks currently being mitigated:

- Workforce to staff schemes: attraction and retention which will be mitigated through skill mix, new lower band roles and continued training for practitioners (Primary/Community)
- No identified funding to progress HFpEF thereby inequalities and inequities will be sustained

Alignment to the integrated care strategy:

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

Diabetes; BHR system – SRO: Jeremy Kidd (jeremy.kidd1@nhs.net)

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

By 2024

- The number of BHR residents with diabetes (T2) receiving eight care processes (8CP) in primary care increase in number (70%+); the quality of process checks improves allowing both better health and early referral when necessary (e.g. foot health or renal)
- CYP diagnosed with diabetes (T1) are supported by a Transition service (ages 12-25) that equips them for later-life and is supported by new capabilities of Insulin Pumps and Continuous Glucose Monitoring (CGM) – which are also for adult residents
- PCN leadership at Place establishes community links with residents (LA supported and via charities, faith groups and schools) that begin to address false beliefs about diabetes and promotes life-style change. This supports reduction in the at-risk of diabetes cohort (NDH) and pilots capability around diabetes remission.
- Review of pathway and referral thresholds increases workforce empowerment and resident access.

By 2026

- Improved health and wellbeing for residents, particularly those with long term conditions
- The level of 8CP delivery is high (80%+) and stable; year-on-year improvements in numbers controlled (target 70%+); QI improvements have led to improved referrals and starting to reduce care required for complications (e.g. amputations)
- CYP capacity at acute improved by Transition services whose first 'graduates' are expert-users in Pump and CGM technology which reduces hospital care and improves quality of life; advice to pregnant woman with diabetes, as well as those planning pregnancy, reduces complications including avoidable birth defects
- Place-based networks for diabetes are maturing and providing contact-points for local residents either who have diabetes, are concerned about diabetes for themselves or friends/family or generally want to live healthier.
- New capabilities of Insulin Pumps and CGM are present in acute and community; this improves quality of life, employment options and reduces emergency care; workforce skills are enhanced and NEL starts be known as a great place to deliver diabetes care
- Residents know where, when and how to access the care they need for the assessment and management of long-term conditions; no longer have to 'feel worse' to receive care
- Residents with health conditions will be assessed, identified and provided with condition management as early as possible.

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

- Primary care delivery of diabetes care was significantly impacted by Covid-19; the evidence shows that in London that residents with diabetes but who did not get Covid-19 have experienced an increased death-rate. In addition, deprivation, ethnicity and the greater incidence of key workers in East London increases the risk to residents with diabetes.
- The current service gap of no CYP Transition service was highlighted by a GIRFT peer-review of BHRUT and contrasts with BH Trust which was funded to pilot Transition services. Similarly, offering Insulin Pumps in BHR will match BHRUT to BH capabilities, while a comprehensive offer of a CGM capability across NEL has potential to radically improve the lives of residents of working-age who suffer poor diabetic control.
- Place-based community mobilisation around living with or avoiding diabetes will be critical in arresting the current growth of diabetes trajectories which will otherwise undercut our residents economic prosperity and our health economy; this work needs to be community and culturally informed.

Key programme features and milestones:

- Establish Governance for 2023-24 and forward, including linkage to Place
- Primary care (Q1-Q4)
  - Delivery of LTC LIS and transition to LTC Outcomes Framework
  - Develop PCN diabetes leadership and their mobilisation of Place networks
  - Training and QI programmes
  - Review Injectables (Q2)
- Business cases; for Transition, Insulin Pumps, CGM and Community Redesign (Q1)
- Full system diabetes pathway review and criteria
- Secondary
  - Recruit lead consultant for Transition plus other staff for team (Q3)
  - Plan Pumps and CGM programme with Community Care (Q2)
  - Start Transition, Pumps and CGM (earliest Q3 or by Q4)
  - Develop a NEL CVD Strategy (Q2 23/24)
  - Start MH (T1) service (Q2)
- Community
  - Review BHR services to equalise offer (Q1-Q3)
  - Move to new delivery model (Q4 and developed through 2024-25)
- Other; work with enablers, e.g. CEPN, CEG etc.

Further transformation to be planned in this area:

- Over next two to five years
  - ➢ Patient Education; develop resident appropriate options and healthy-living programmes that resident want to complete
  - ➢ Integration with related schemes as they develop e.g. Obesity, Hypertension, Renal
  - ➢ Providing support to enable independent living for as long as possible via the development of integrated teams

Programme funding*:

Currently costed scheme,

- Transition service* £365k,
- Primary care; £1,800k

Schemes being estimated

- Pumps, CGM* £600k
- Community care redesign* (too early)

* Sources of funding to be identified

Leadership and governance arrangements:

- Level 1 – BHR LTC Board (or its successor)
- Level 2 – NEL Diabetes Partnership Board
- Level 3 (operational) – Diabetes Operational Working Group (or its successor)

Success will need co-ordination or contract management with:

- Networks; NHSE London, Primary Care (local and London), CVD, Obesity, Renal, Hypertension, UCLP
- Partners; BHRUT, NELFT, PCNs, Prescribing
- Other providers; Xyla, CEG, Oviva, Federations, et al.

Key delivery risks currently being mitigated:

- Funding: low availability or funds will supress transformation plans; mitigate through work understanding whole-system-impact and efficiencies of
- Workforce: attraction and retention could limit development; mitigate through inter-provider work and skills transfer (e.g. pumps) plus training (CEPN)

Alignment to the integrated care strategy:

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