North East London Health & Care Partnership

NHS North East London

North East London Integrated Care Strategy development

Joint Overview and Scrutiny Committee

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Introduction

- In July our **Integrated Care Partnership** was formally established. This is a statutory committee that brings together a broad set of system partners (including local government, the voluntary, community and social enterprise sector, NHS organisations and others) to develop an **integrated care strategy** for the area.

- The Department for Health and Social Care has issued **guidance for integrated care strategies** with a suggestion that partnerships may wish to develop interim strategies in order to influence system planning for 23/24 ahead of further strategy guidance expected in June 2023.

- System partners across North East London Health and Care Partnership have already reached collective agreement on **our ICS purpose and four priorities** to focus on together as a system . These priorities will be at the heart of our integrated care strategy in NEL.

- Broad system-wide engagement including a series of well attended system-wide stakeholder workshops, and discussions with Health and Wellbeing Boards and place based partnerships has shaped our plans for progressing the four system priorities. Our engagement has also identified six cross-cutting themes describing ‘how’ we will work differently as an integrated care system. The priorities and cross-cutting themes will set a clear direction for the development of the new NHS Joint Forward Plan due end March 2023.

- While the strategy has been informed by discussions with local people and existing insights via Healthwatch, the key messages, priorities and success measures will be tested further with local people through a ‘Big Conversation’ planned to take place in Spring 2023.

- The interim strategy document will be completed taking on board any further feedback from the Integrated Care Partnership on 11 January. The strategy will not however be a one–off process, more a dynamic dialogue across all parts of the system and with local people.

Following the next slide where we have suggested some questions for discussion, we have included draft content in development on the four system priorities and six cross-cutting themes. We are continuing to develop the other sections of the strategy which include the introduction and context, overview of our population, and a section at the end on the foundations of a well-functioning integrated system.

Questions for discussion

1. Are there any key areas missing from our priorities or cross-cutting themes or anything we need to emphasise differently particularly at this stage in order to influence the NHS Joint Forward Plan?

2. Have we set the right level of ambition and scope in our success measures for the new system strategy?

Draft content

Improving outcomes and tackling inequalities - our four system priorities

To provide the best start in life for the Babies, Children and Young People of North East London

Our context and case for change-

- Babies, children and young people comprise one quarter of our population.
- In all our places except Hackney and Havering we have a higher proportion of babies born with a low birth weight than the England average. Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life.
- In all our places except Havering, we have a higher percentage of children living in poverty than the England average (15.6%). This is likely to have been exacerbated by recent challenges including the pandemic and cost of living pressures. There is a strong link between childhood poverty and poorer health outcomes including premature mortality. There is also evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health.
- Assessments indicate that 38,000 pupils in north east London need special educational support. 13,600 of these pupils have Educational, Health and Care Plans which outline the support they receive and these numbers are increasing.
- In all places in NEL, overweight and obesity in children is higher than the England average (35%). Barking and Dagenham and Newham respectively have the highest and fifth highest rates in England. Dental decay in 5-year olds is also higher in all our places compared to England.
- We saw physical and mental health outcomes deteriorate during the Covid-19 pandemic, particularly for vulnerable children and those with long term conditions within disadvantaged communities. In north east London at least 18,099 children and young people have asthma, 1,370 have epilepsy and 925 have type 1 diabetes.
- We are currently seeing substantial pressures on child health urgent care services which is likely to be connected to the recent pandemic and cost of living pressures.
- Currently there are 3,343 babies, children and young people in north east London with life limiting conditions requiring palliative and end of life care, and this number is gradually increasing.

Key messages we heard through our engagement

Support for young people feels unequal, and varies depending on stage of life.

I want to be involved in decisions about my care, and I don't always feel that my needs are understood.

The care I receive feels rushed and impersonal, and has varied in quality across services and at different stages of my life.

What we need to do differently as a system

Create the conditions for our staff to do their best possible work including creating a safe multi-disciplinary learning environment spanning teams across north east London, provider collaboratives and place-based partnerships with a focus on co-production, quality improvement and trauma-informed care.

Focus on tackling health inequalities by working with our place-based partnerships to increase support for our most vulnerable children and their families, developing an enabling programme of work which addresses workforce challenges, supports data capture and benchmarking, and promotes better communication.

Develop clearly defined prevention priorities supporting place-based partnerships to focus on the most deprived 20% of the population and other underserved groups, as well as a focus across north east London on prevention priorities including obesity and oral health.

Develop community-based holistic care, building community capacity, aligning to family hubs and strengthening adolescent healthcare. Through social prescribing and multi-disciplinary teams we will enable links to community assets including the community and voluntary sector and put health inequalities at the heart of our work

Prioritise our children and young people's mental health, recognising the importance of support, and timely access to information, advice and care. We will harness the potential of the digital offer and work with children and young people to design and deliver high quality, accessible services in a range of settings.

Improve prevention and support for babies, children and young people with long term conditions such as asthma, diabetes and epilepsy, by supporting greater personalisation of care and prevention activities across north east London.

What success will look like for local people

- *I have the same experiences and range of support for my development, health and wellbeing, no matter where I grow up in north east London*
- *I have the opportunity to access healthcare, education and care in ways that suit me and my goals*
- *I receive high quality and timely personalised care at a place of my choice*
- *I am treated with kindness, compassion, respect, information and communication is accessible and understandable*
- *I have opportunities to share my experience and insight, and seen change that I have influenced*
- *I have people who treat and look after me care as I move through the different stages of my life*
- *I am involved in decisions about my care*

What success will look like as outcomes for our population

- Reduce proportion of babies born with low birth weight in north east London
- Identify children living in poverty within our communities and ensure they are receiving the support they need to live a healthy life including equitable access to and outcomes from our health and care services
- Strengthen our focus on prevention, reducing levels of childhood obesity and dental decay and increasing uptake of childhood immunisation
- Strengthen our support for children living with long term conditions and address health inequalities by reducing the number of asthma attacks, increasing access to prevention and self-management for children and young people with diabetes (particularly those living in poverty or deprivation and those from black and ethnic minority backgrounds), increasing access to specialist epilepsy support for children, including those with learning disabilities and autism
- Improve access to children and young people's mental health services, and support young people better through the transition to adult mental health services
- Reduce the number of young people reporting that they feel lonely and isolated
- Collaborate between education, health and social care to meet the needs of children with special educational needs and disability

To support everyone at risk of developing or living with a long term condition in north east London to live a longer and healthier life

Our context and case for change

- 31% of our residents have a long term condition. Living with a long term condition can impact on many aspects of a person's life, including their family and friends and their work. People with a long term condition are more likely to suffer from further conditions or complications over time, including poor mental health.
- Long terms conditions account for half of GP appointments, 70% of inpatient bed days and 70% of the acute care budget.
- Long term conditions cannot be cured but when managed effectively, the impact the condition has on a person and their life can often be alleviated or delayed. Some long term conditions can also be prevented completely through healthier behaviours.
- 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 per cent higher prevalence of long term conditions than the wealthiest and 30 per cent higher severity of disease. People of South Asian ethnic origin are at greater risk of developing Type 2 Diabetes, and people with an African or Caribbean family background are at greater risk of sickle cell disease.
- Our population has a higher prevalence of type 2 diabetes, and several other conditions including hypertension and chronic kidney disease as well as a higher mortality rate for cardiovascular disease in the under 75s. One in five of our residents has respiratory disease. Further, there are likely to be high levels of unmet need – highest in our 'underserved' communities - that are not showing in the data but require proactive identification and better management.
- Two-thirds of people with at least one long term condition have more than one mental health problem, including depression and/or anxiety, and there is a growing connection between living with a long term condition, social isolation and low self-esteem.

Key messages we heard through our engagement

Care for people with long term conditions feels unco-ordinated and fragmented.

I am not always clear who I can turn to with a problem, where I can access non-medical support in my local community or support with my emotional and psychological wellbeing.

I do not want to be asked to repeat my story to different professionals and I want my transition from service to service to be much better co-ordinated and supported.

What we need to do differently as a system

Better coordination of care, including between mental and physical health, and better transitions between different services, such as between child to adult services.

Empower and resource local communities and voluntary organisations to increase support for prevention and self-management, de-medicalising and destigmatising day to day support for long term conditions through social prescribing, increasing access to emotional and psychological support and widening peer support.

More consistent communication with people living with long term conditions and their carers, including in relation to their end of life care. Ensuring that people are at the heart of every conversation and that we focus on their holistic needs and strengths (not just their care).

Support health creation within local communities, increasing opportunities and support for making healthier choices, including starting health and well-being conversations in early years and working together to reduce the number of people in north east London living with risk factors such as obesity or smoking.

Lead by example as a large employer across north east London. Through our priority on workforce and local employment we will identify what more we can do as employers to encourage healthy behaviours and to support colleagues with long term conditions. We will also do more to value and support informal carers in recognition of the significant contribution they make to the health, wellbeing and independence of local people.

More intelligent identification of those with long term conditions or risk factors to support those affected to take earlier and more proactive action particularly among 'underserved' communities where there are high levels of unmet need.

What success will look like for local people

- *I receive the support I need to make healthier life choices, increasing my chances of a long and healthy life*
- *If I develop a long term condition, it will be identified early and I will be supported through diagnosis; with my individual needs taken into account*
- *I feel confident to manage my own condition, and there is no decision about me without me*
- *I am able to access timely care and support from the right people in the right place*
- *I feel my quality of life is better because of the care and support I received*
- *I am able to care for my loved one, my contribution is recognised and valued and help is there for me when I need it*

What success will look like as outcomes for our population

- Reduce prevalence of obesity and we will be smokefree by 2030
- Reduce the number of people with long term conditions diagnosed in an urgent care setting and increase early diagnosis of cancer
- Increase uptake of vaccines for people with chronic respiratory conditions to prevent more emergency hospital admissions
- Increase hypertension case finding in primary care to minimise the risk of heart attack and stroke within our population
- Increase the proportion of local people who say that they are able to manage their condition well
- Increase the proportion of local people who are able to work and carry out day-to-day activities whilst living with a long term condition
- Improve the mental health and wellbeing of people with long term conditions and their carers

To improve the mental health and wellbeing of the people of north east London

Our context and case for change

- Mental health affects how we think, feel and act, and has a profound impact on our day-to-day lives. It is strongly linked with wider health outcomes and therefore improvements here impact our overall ambition to improve the lives of people living in north east London.
- We are seeing a growing number of people in need of our mental health services. Recorded rates of depression have increased year-on-year in every borough in north east London over the past 5 years.
- The Covid-19 pandemic and cost of living crisis has brought new challenges, exacerbated inequalities, and often it has been those who were struggling before that are now being hit hardest. The number of referrals received across North East London Foundation Trust Mental Health Services has steadily increased since the pandemic began in early 2020 and is currently up 18.5% on the previous year.
- There has been a steady increase in demand for crisis support for children and young people by 82% between July 2020 and July 2022. Children and Young Adults Mental Health Services (CAMHS) have started to see crisis presentations stabilise, although referrals across most services continue to be higher than pre-pandemic levels.
- We still have further to go to ensure that people with mental and physical health conditions, including across their life course and people with dementia, get the right integrated support, as early as possible.

Key messages we heard through our engagement

I want those providing my support to consider me as a whole person

I want to access support in different ways that suit me and my goals, not just what is available and not when it is too late

I want to tell my story once and be involved in deciding what support will suit me and my family's, goals and needs

What we need to do differently as a system

Prioritising what matters to service users, carers and people with lived experience, so that service users and carers have an improved quality of life, with joined-up support around the social determinants of health.

Delivering local priorities for mental health, including the assets, wishes and aspirations of our communities, and the unmet needs and inequalities facing specific groups.

Improving access and integration, reducing inequality of access, and improving people's first contact with mental health services including ensuring that local people can access the support they need in the place that best placed for addressing their needs.

Enabling and supporting patient leadership at every level in the system so that service users are equally valued for their leadership skills and experience as clinicians, commissioners and other professionals.

Embedding and standardising our approach to peer support across north east London so that it is valued and respected as a profession in its own right, and forms part of the multi-disciplinary team within clinical teams and services.

Improving cultural awareness and cultural competence across north east London so that people with protected characteristics feel they are seen as individuals, and that staff are not making assumptions about them based on those characteristics.

Valuing the contribution of carers and providing more and better support to them so that they are able to provide better support for others as well as improve their own health and wellbeing.

What success will look like for local people

- *I feel happy and healthy in my life*
- *I have the same chances in life as my peers without adversity or vulnerability, we aren't hard to reach*
- *I am supported to get involved and see changes that I have influenced*
- *I have the same experience and access to a range of support regardless of where I live or go to school*
- *I am able to see all support available to me, my family and friends in one place*
- *I feel I have ownership of maintaining and improving my resilience and wellbeing*

What success will look like as outcomes for our population

- Increase the number of people diagnosed with dementia and improve support to people and their carers before and after diagnosis
- Address under-representation of people from black, Asian, and minority ethnic communities in talking therapy services
- Improve the physical health and premature mortality of people with a serious mental illness including ensuring annual health checks for at least 60%
- Increasing the availability and timely access for preventative mental health and wellbeing services for children and young people, particularly within schools and including increasing the number of schools covered by a Mental Health Support Team
- Increase the number of carers referred to IAPT services
- Create new peer support roles and increase the number of paid peer support workers
- Increase training for non-mental health specialists including receptions staff
- Reduce the gap in employment rate for people with long term mental health needs.

To create meaningful work opportunities and employment for people in north east London now and in the future

Our context and case for change

- North east London has almost one hundred thousand staff working in health and care, with over 4,000 in general practice, 46,000 in social care, and around 49,000 within our trusts. Our workforce are the heart of our system and play a central role in improving population health and care.
- Alongside our paid workforce, our thousands of informal carers play a pivotal role in supporting family and friends in their care, including enabling them to live independently. Analysis undertaken by Healthwatch shows inequalities of experiences for carers who have poor experiences in accessing long term conditions (51%) and mental health services (70%), between 61% and 73% did not feel involved and supported.
- Our employed workforce has grown by 1,840 people in the last year. Investment in primary care workforce has seen numbers grow by 3.7% in the last year, as well as a growth in training places for GPs.
- Retention and growth are a key part of all our workforce plans but we still have a number of challenges to overcome. We have an annual staff turnover rate of 23%, and we have heard from staff that burnout has been a growing problem after the Covid-19 pandemic.
- The interplay of increased workload and stress due to the pandemic is still having an effect. Sickness rates for north east London were higher than the national average of 4%, at 4.9%. Although we have the second lowest sickness rate in London, we know that mental health issues are the second highest reason for sickness, behind musculoskeletal problems.
- To achieve our ambitions as an integrated care system we need our workforce to be equipped with the right skills, values and behaviours to deliver our health and care services. To meet rising demand as our population grows and their health and care needs become more complex, we will also need staff to work in different ways, potentially in new roles, as models of care are adapted and improved.

Key messages we heard through our engagement

I value flexibility and work life balance over traditional rewards such as pensions

I want career development and career growth opportunities available to me locally

I felt over-worked before the pandemic and now it's really affecting my ability to work

I'm a local person with transferable skills but I don't feel local health and care jobs are accessible to me

I want the informal care I provide valued and supported

What we need to do differently as a system

Employ more local people supported by efficient, streamlined, and accessible recruitment processes, promoting diversity and ensuring that under-represented groups have the opportunity to be employed in our services. We will contribute to the local economy by upskilling and employing local people who are unemployed or at risk of unemployment as well as investing in growing our own workforce from within, creating a consistent pipeline in partnership with our education institutions, and utilising system-wide approaches for all sectors.

Work collaboratively to develop one workforce across health and care in north east London. We will work together to develop a deal that all employers will offer with a focus on flexible career development and improved access to a consistent wellbeing and training offer shared across providers.

Work together to progress the London Living Wage commitments across north East London.

Prioritise retention of our current workforce, and create the opportunities for development across organisations to ensure that we have a stable and high performing workforce in all services. We will develop system approaches to career pathways, leadership and development.

Support the health and wellbeing of our staff, with a consistent offer of support for staff which recognises the challenges brought by the Covid-19 pandemic and current cost of living crisis.

Develop and recognise our social care and voluntary workforce and prioritise specific retention programmes, ensuring that they have support when needed.

Value the contribution of carers and provide more and better support to them so that they are able to provide better support for others as well as improve their own health and wellbeing.

What success will look like for our people

- *Working in health and care in north east London, I feel valued and respected*
- *I have meaningful work and am able to support myself and my family financially*
- *I have access to training and career development opportunities whichever part of the local health and care system I am currently working within*
- *I feel I have local employment and volunteering opportunities across a range of health and care settings, regardless of my background*
- *I am able to care for my loved one, my contribution is recognised and valued, and help is there for me when I need it*

What success will look like as outcomes for our people

- Increase the number of local residents working in health and social care, ensuring that our workforce is representative of the community it serves.
- Our carers feel supported, valued and provided with the skills to deliver personalised care to meet the needs of our residents.
- Consistent and joint financial approach between health and care to avoid inequity across health and care sectors.
- Staff will be able to transfer easily between employers in health and care
- All staff in all sectors will have access to a consistent health and well-being offer, building on our Keeping Well NEL platform that supports staff retention.
- As part of our employment deal, a consistent offer of development, flexibility and mobility that all organisations in north east London sign up to, including recognition of skills across sectors and professions.
- We are increasing the ethnic diversity of board level and senior leadership to reflect the make-up of the population in NEL

Draft content

How we work as an integrated care system – our 6 cross cutting themes

Equity

Working together as a system to tackle **health inequalities** including a relentless focus on equity underpinning all that we do

What success will look like for our system

In addition to the specific health inequalities measures set out in relation to our four priorities above:

- Across north east London we are reducing the difference in access, outcomes and experience with a focus on people from black and minority ethnic communities, people with learning disabilities, people who are homeless, people living in poverty or deprivation and for carers.
- Healthy life expectancy is improved across NEL and the gap between our most and least deprived areas / those living in poverty and the wealthiest is reduced.
- We have improved ethnicity data collection and recording across health and care services and deliver inclusive, culturally competent and trusted health and care services to our population.
- Our staff have access to training on health inequalities and we routinely measure and address equity in NHS waiting lists.
- We are mitigating against digital exclusion.
- Tackle racism and increase cultural competence and cultural awareness in services

Prevention

A greater focus on prevention and **health creation** across the whole of our system including **primary** and **secondary prevention** and the wider determinants of health.

What success will look like for our system

In addition to the specific prevention measures set out in relation to our four priorities:

- We invest more in prevention as a system to reduce prevalence of long term conditions and mental health equitably across all of our places.
- We identify and address unmet need including diagnosing more people early and increasing access to care and support particularly for our most vulnerable or underserved groups.
- We invest in our community and voluntary sector to support prevention and early intervention in a range of ways to suit our diverse population.
- Through our role as anchor institutions, we support economic development by emplying local people and prioritising social value in procurement.
- We share and use data to identify the most vulnerable people living locally including those not using services and those frequently using services to provide more targeted and proactive support which better meets their needs.

Personalisation

We will deliver health and care that is **holistic, personalised and trauma–informed** supported by seamless integration across service and organisational boundaries.

What success will look like for our system

- Staff have access to all the information they need in one place to enable them to provide seamless care to local people and can share this information safely through our IT systems.
- Local people including carers only need to tell their story once through their health and care journey.
- 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 residents are identified and given additional support to access services ensuring their experience and outcomes of care are equitable.
- Our staff are equipped to deliver trauma-informed care based on the principles of physical and psychological safety; trust; choice; collaboration; empowerment; and cultural competence.

Co-production with local people and all partners, particularly drawing on the **strengths and assets** of individuals and communities, rebalancing power.

What success will look like for our system

- We can evidence how decisions taken by our boards are informed by the views of local people.
- We helped establish a community and voluntary sector collaborative and actively support and resource its development.
- We train a wide range of health and care staff in co-production and power sharing approaches.
- We can demonstrate how we have identified and engaged underserved groups and the full diversity of our local population.
- We use existing sources of insight from local people including carers to shape our strategies and plans and resist repeatedly asking the same questions.
- We close the loop when we seek the views of carers and local people by feeding back.

High trust We will endeavour to develop a high trust environment supporting **partnership working, collaboration** and **integration** across the whole of our system, with the contribution all partners valued equally.

What success will look like for our system

- Partners in the ICS feel actively engaged
- Partners have adopted an ‘open book’ approach including how we spend our money
- We challenge each other constructively without blame
- We are open to new ways of working and share risk as a system

Learning system We will work as a learning health and care system making the best use of **data, evidence, research** and **insight** to drive continuous development and **improvement,** encourage **innovation** and accelerate progress through shared learning.

What success will look like for our system

- We use data, evidence and insights to build our understanding of our population and to drive our ambitions, priorities, transformation and improvements.
- We regularly review the impact we are having through evaluation of our services and transformation programmes and make changes based on this learning.
- We innovate and enable shared learning to accelerate adoption of innovation, research and best practice throughout our system.
- We support and encourage research that is focused on improving health and care for local people and involve more local people in research