LONDON BOROUGH OF WALTHAM FOREST

INNER NORTH EAST LONDON JOINT HEALTH AND OVERVIEW SCRUTINY COMMITTEE

DAY/DATE/TIME	VENUE:
Wednesday, 12 July 2023 7.00 pm	COUNCIL CHAMBER - WALTHAM FOREST TOWN HALL Fellowship Square Forest Road, E17 4JF The meeting can be viewed here: https://www.civico.net/walthamforest
CONTACT:	TEL./E-MAIL:
Anthony Jackson Democratic Services	democraticservices@walthamforest.gov.uk

Dear Member,

This is formal notice advising you of the above meeting. The Agenda is set out below. Supplementary Items will be added only if the Chair considers them urgent.

Martin Esom
CHIEF EXECUTIVE

MEMBERSHIP:

Councillors: Councillor Afzal Akram, Councillor Richard Sweden and Councillor Jennifer Whilby

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Contact details for report authors are shown on individual reports. Report authors should be contacted prior to the meeting if further information on specific reports is needed of if background documents are required.

Disclosable Pecuniary Interests (DPI) are prescribed by the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012 as follows:

Interest	Description
Employment, office, trade, profession or vocation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by a member in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

A Member must disclose at meetings as a **non-pecuniary interest**:

- Appointments made by the authority to any outside bodies (excluding joint committees with other local authorities);
- Membership of charities;
- Membership of trade unions recognised by the authority;
- Membership of lobbying or campaign groups;
- Governorships at any educational institution in the borough;
- Membership of voluntary organisations operating in the borough.

General Dispensation

In accordance with s33(2) of the Localism Act, 2011, the Monitoring Officer has granted dispensations to all Councillors until the Annual General Meeting of Council in 2018.

The grounds for the dispensations are that:

- Granting the dispensation is in the interests of persons living in the authority's area(s33(2)(c)) of the Localism Act 2011) by allowing their elected representatives to participate and vote on the Council's budget and council tax setting: and
- It is otherwise appropriate to grant a dispensation (s33(2)(e))

in that the dispensation will allow members to fully represent their constituents in respect of these important matters.

Monitoring Officer's guidance on bias and pre-determination

The Council often has to make controversial decisions that affect people adversely and this can place individual councillors in a difficult position. They are expected to represent the interests of their constituents and political party and have strong views but it is also a well-established legal principle that councillors who make these decisions must not be biased nor must they have pre-determined the outcome of the decision. This is especially so in "quasi-judicial" decisions in planning and licensing committees.

This Note seeks to provide guidance on what is legally permissible and when members may participate in decisions. It should be read alongside the Code of Conduct.

Predisposition

Predisposition is lawful. The law is very clear that members may have strong views on a proposed decision, and indeed may have expressed those views in public, and still participate in a decision. This will include political views and manifesto commitments. The key issue is that the member ensures that their predisposition does not prevent them from consideration of all the other factors that are relevant to a decision, such as committee reports, supporting documents and the views of objectors. In other words, the member retains an "open mind".

Section 25 of the Localism Act 2011 confirms this position by providing that a decision will not be unlawful because of an allegation of bias or pre-determination "just because" a member has done anything that would indicate what view they may take in relation to a matter relevant to a decision. However, if a member has done something more than indicate a view on a decision, this may be unlawful bias or predetermination so it is important that advice is sought where this may be the case.

Pre-determination / Bias

Pre-determination and bias are unlawful and can make a decision unlawful. Pre-determination means having a "closed mind". In other words, a member has made his/her mind up on a decision before considering or hearing all the relevant evidence.

Bias can also arise from a member's relationships or interests, as well as their state of mind. The Code of Conduct's requirement to declare interests and withdraw from meetings prevents most obvious forms of bias, e.g. not deciding your own planning application. However, members may also consider that a "non-pecuniary interest" under the Code also gives rise to a risk of what is called apparent bias. The legal test is: "whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased'.

A fair minded observer takes an objective and balanced view of the situation but Members who think that they have a relationship or interest that may raise a possibility of bias, should seek legal advice.

This is a complex area and this note should be read as general guidance only. Members who need advice on individual decisions, should contact the Monitoring Officer and / or the legal advisor for their committee.

AGENDA

1. APOLOGIES FOR ABSENCE AND SUBSTITUTE MEMBERS

2. DECLARATIONS OF INTEREST

Members are required to declare any pecuniary or non-pecuniary interest they or their spouse/partner may have in any matter that is to be considered at this meeting. Interests are defined in the front cover of this agenda.

3. MINUTES OF THE PREVIOUS MEETING (Pages 7 - 18)

4. PUBLIC PARTICIPATION (Pages 19 - 26)

Members of the public are welcome to participate in scrutiny meetings. You may speak for three minutes on a topic related to the Committee's work, and fifteen minutes in total is allowed for public speaking, at the discretion of the Chair. If you would like to speak, please contact Democratic Services (details above) by 12 noon on the day before the meeting.

(i) Paul Atkinson to address the Committee regarding North East London Talking Therapies (written submission is enclosed within the agenda pack).

5. COLLABORATIVES (Pages 27 - 44)

6. HEALTH UPDATE (Pages 45 - 62)

including slides on:

- NEL Big conversation and staffing structure
- Financial environment and operating plan
- Strike action and Trust updates (BH/ELFT/NELFT/Homerton)

7. ICS FIVE YEAR FORWARD PLAN (Pages 63 - 122)

8. SYSTEM RECOVERY AND RESILIENCE (Pages 123 - 150)

- Place partnership mutual accountability framework
- System recovery and resilience in Urgent and Emergency Care

9. CONTINUING HEALTHCARE POLICIES (Pages 151 -

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Inner North East London Joint Health Overview and Scrutiny Committee (INEL JHOSC)

Council, Chamber,
Hackney Town Hall,
Mare St, London E8 1EA

Date of meeting: Tue 28 February 2023 at 7.00pm

Chair	Councillor Ben Hayhurst (Hackney)
Members in attendance	Councillor Ahmodur Rahman Khan (Tower Hamlets) Councillor Susan Masters (Newham) Councillor Sharon Patrick (Hackney) Common Councilman David Sales (City of London) Councillor Richard Sweden (Waltham Forest)
All others in attendance remotely	Councillor Beverley Brewer (Redbridge) (ONEL Observer) Cllr Harvinder Singh Virdee (Newham) Rt Hon Jacqui Smith, Chair in Common, Barts Health-BHRUT Shane DeGaris, Group Chief Executive, Barts Health-BHRUT Louise Ashley, Chief Executive, Homerton Healthcare Marie Gabriel CBE, Independent Chair, NHS NEL Zina Etheridge, Chief Executive, NHS NEL Diane Jones, Chief Nursing Officer, NHS NEL Clive Walsh, Interim Director of Performance, NHS NEL Ashleigh Milson, Senior Public Affairs Manager, NHS NEL Dr Victoria Tzortziou Brown OBE, NEL Health and Care Partnership Cllr Chris Kennedy, Cabinet Member for Health, Hackney Council Roger Raymony, Senior Scrutiny Officer, Newham Council
Member apologies:	Councillor Afzal Akram (Waltham Forest) Councillor Kam Adams (Hackney) Councillor Catherine Deakin (Waltham Forest) (Vice Chair)
YouTube link	The meeting can be viewed here: https://youtu.be/Fyr2lM2En4o
Officer contact:	Jarlath O'Connell; 020 8356 3309; jarlath.oconnell@hackney.gov.uk

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1. Welcome and apologies for absence

1.1 Apologies for absence were received from Cllrs Adams, Akram and Deakin and from Paul Calaminus and Jacqui Van Rossum

1.2 It was noted that Cllrs Virdee and Brewer were joining remotely.

1.3 The Chair thanked Ashleigh Milson who was the link officer for this Committee at NHS NEL and wished her well in her new post at LAS.

2. Urgent items order of business

2.1 There were none and the order of business was as on the agenda.

3. Declarations of interest

3.1 Cllr Masters stated she was employed as Director Health Transformation by Hackney Council for Voluntary Services, in a post funded by NHS NEL.

4. Understanding ICS staffing at Place level

4.1 The Chair stated that one of the issues which as caused some concern over the period of the development of the ICS was how the new body, NHS NEL, will work vis a vis the old CCG system and in particular the need to preserve valuable local knowledge from 'Place' level in the new, more centralised commissioning structure. He had invited the CE of NHS NEL therefore, to give a briefing on this.

4.2 Members gave consideration to a briefing paper - *Understanding staff at place level.*

4.3 The Chair welcomed Zina Etheridge (**ZE**), Chief Executive Officer, NHS NEL, who took Members through the briefing which covered: *Background, Place partnership principles, and staffing.*

4.4 ZE explained that the new structure would go live on 1 July and that any matter involving staffing was sensitive to the individuals involved which therefore limited the amount of detail she could give at this stage. She reiterated that Place was fundamental to their work collectively and in partnerships.

4.5 The Chair asked whether there would be an anchor level of staffing at Place level. ZE stated that it had not been agreed yet as the current contractual arrangements of staff varied quite widely The aspiration was that staff working at Place would spend some of their time in that Place.

4.6 The Chair asked if there would be delegation of finances to the Place based structures and what attempts were being made to retain staff with local knowledge in broadly the same roles. ZE replied that local knowledge of Primary Care would be the cornerstone of the model going forward. They already had a Primary Care Improvement Lead and a Primary Care Clinical Lead in each Place. On financial delegation she stated it was their intention that Places would have a very real role in setting the objectives for their

communities. She added that the leadership team all recognised this aspiration and acknowledged the concerns and so were, for example, updating the Terms of Reference for the Place Committees so that more delegation would be put in place from April.

4.7 Cllr Brewer asked whether NHS NEL had the balance right for resourcing staffing at Place level. ZE replied that the ICB budget was made up from a number of sources, some Programme Funded costs and some other costs. The answer on the size of the budget depended on which elements you included. On staff numbers in the structure, she was not able to confirm any of that as yet because it had not yet been set out for staff.

4.8 Cllr Masters expressed concern that previous promises about subsidiarity appeared to be fading and asked about how best practice programmes on reducing inequalities were operating. ZE explained that the Population Health and Integration Cttee chaired by Marie Gabriel was key here and Place Committees sit within that structure. They have a series of pieces of work focusing on reducing health inequalities driven by what was set out in the recently published Integrated Care Strategy. They look at inequality through a lot of different lenses. Acutes look at waiting lists, mental health acutes look at it via the various improvement programmes they have in place. Place, being at the heart of local communities, then will feed into this work. She gave the example of the 'Health Spot' in Poplar,which she had just visited and which provided access to primary care to young people by linking with youth provision. This focus on young people and teens accessing primary care was innovative as this had been an under examined area.

4.9 The Chair asked about the different pressure points on NHS NEL including presumably a requirement to deliver savings but added that the reference in the paper to "System and Place are one" didn't exactly point to an ethos favouring delegation. ZE apologised if subsidiarity was not coming out strongly enough. They were committed to Pace being the most important unit in terms of tackling health inequalities. There would continue to be a need for central functions as well as the need to work closely within the Provider Collaboratives. Both approaches are needed, she added, to tackle unwarranted variations in health outcomes across the patch. At the System Level the intention is to do, and only once, at that level what needs to be done at that level. She explained that there is a whole range of functions and statutory duties and their associated regulations that they have to meet and that needs to be delivered within a budget envelope set by NHSE.

4.10 The Chair asked if it has been nationally mandated that admin spend must be less than under the old system. ZE replied that when looking at their current restructure plans part of the exercise was to explore a range of alternative scenarios where they'd be required to deliver against different financial envelopes. The Chair stated that the Committee was appreciative of the efforts by ZE and colleagues to avoid a 'one size fits all' approach across NEL, thus recognizing that different localities have different constraints on them. Cllr Kennedy, the Cabinet Member for Health from Hackney, added that he was grateful to ZE for allowing City and Hackney to retain the jointly funded Director of Delivery, as it had worked very well for them.

4.11 The Chair asked if the new staff structure would be in place by 1 July. ZE replied that staff had to be consulted first adding that the timeline had slipped. Once these were agreed she undertook to provide a written update for the

Committee. She added that a restructure was complex and included a consultation process which would take time. The Chair commented that while City and Hackney for example was pleased with its Clinical Lead in Primary Care for example, they would still prefer there to be a core local admin lead on Primary Care who was not clinical but had the in-depth local knowledge.

ACTION:	**CE of NHS NEL to provide an update to the next appropriate meeting on the agreed staffing structure, the 'Local Accountability Framework' and the 'Financial Framework'.**

RESOLVED:	**That the report be noted.**

5. NHS NEL Health Updates

5.1 The Chair explained that this item allowed us to hear updates from the key local trusts. He welcomed for the item:

Shane DeGaris (**SD**), Group Chief Executive Barts Health/BHRUT
Louise Ashley (**LA**), Chief Executive of Homerton Healthcare
Rt Hon Jacqui Smith (**JS**), Chair in Common, Barts Health-BHRUT

5.2 Members gave consideration to the report *North East London Health updates* which comprised overview updates from Barts Health, Homerton Healthcare and ELFT/NELFT. SD and LA took members through the report.

5.3 The Chair asked SD how they had made insourcing financially viable. SD replied that a key focus had been bringing staff onto the 'agenda for change' terms and conditions and the move was important in terms of equity for lower paid staff. The increased cost could partly be offset by improvements in ways of working and having a better motivated workforce. There was a net cost but it was the right thing to do, he added.

5.4 The Chair asked SD about sharing the learning from their insourcing journey with Homerton Healthcare. SD explained that this was happening and they also worked closely together in the Acute Provider Collaborative. LA added that she was pleased that it was happening and that they will have an opportunity to learn from it as they make similar considerations.

5.5 The Chair asked LA how the system was adapting to the new Pathology Partnership. LA explained that they had some teething problems in getting the electronic systems working and in sorting out facilities issues in the new Labs but all of these were solvable and it was bedding in. SD added that Lewisham and Greenwich NHS Trust were the third partner here so it was an in-house NHS Pathology Partnership and did not involve the independent sector.

5.6 Cllr Masters asked about keeping across developments at BHRUT and also requested that, in future reports, more data be presented in graphical form so

as to better illustrate trends. SD replied that they had similar slides on BHRUT for use at ONEL but didn't present them here as they understood the focus was INEL, but they could present both in the future. He also undertook to provide more graphical information in future reports. JS added that more information from BHRUT is obviously focused on the ONEL committee. She recalled that she had presented on the Barts Health-BHRUT Collaborative previously and would be happy to do this at the next meeting, to provide an update on the key areas of work.

ACTION:	**'Update from NHS NEL Chair on the progress of the Provider Collaboratives' and a separate 'Update on the Barts Health-BHRUT Collaborative from their Chair in Common' to be added to the agenda for the next meeting.**

5.7 Cllr Sweden asked what other medical conditions would be suitable for the virtual wards approach; about plans for further tranches of in-sourcing; about sharing best practice on IAPT; and on further integration of ELFT and NELFT. SD explained that Virtual Wards were currently used for areas like cardiology and utilise 'remote wearables' and kit that can be used easily at home. There definitely are applications to other illnesses and they were looking at its uses in monitoring 'Frailty' and in other areas. On insourcing, by May, Barts Health would have insourced security, portering, catering, cleaning and car parking so there were only a few small areas remaining. A related issue for Royal London and St Barts however was that they had the largest PFI contract in the country and that 'hard facility' contract was outsourced to the PFI contractor. There were no plans to in-source that because of the scale involved so their focus instead had to be on working with the PFI partner to get best value for the taxpayer. ZE responded on ELFT and NELFT collaboration, describing the two trusts' work on the new Mental Health, Disabilities and Autism Collaborative, the focus of which was to reduce unwarranted clinical variation across NEL as well as working on patient leadership and service user engagement. The Community Health Collaborative had begun but was at a less advanced stage, she added. She offered to provide more information on these at a future meeting. On Homerton Healthcare's strong IAPT performance LA replied that she was very pleased with it and could also update in future if required. She added that when things do go well they should reflect more on that too as that is also important for learning.

ACTION:	**Group CE Barts Health/BHRUT to provide further detail of the type of equipment being used for the 'cardiology at home' Virtual Ward.**

ACTION:	**CE of NHS NEL to join with ELFT and NELT officers to present a future meeting item on the work of both the Mental Health, Disabilities and Autism Collaborative and the Community Health Collaborative.**

5.8 The Chair asked JS what the main focus of work currently was in the Barts-BHRUT Collaborative. JS replied that across the Collaborative and in the wider Acute Provider Collaborative, which also includes the Homerton, they were focusing on 6 clinical areas and research and had a particular focus on 'Workforce' to support challenges at BHRUT. They were working to develop medical education and leadership. She added that in all her visits she would hear staff discuss how they were reaching out to the other Trust to get advice and there were numerous examples of using capacity at one to support the other. She illustrated this with the example of expanding the REACH programme by using consultants in Emergency Medicine at the Royal London to work more closely with paramedics to make sure patients were taken to more appropriate settings than ED, when appropriate.

5.9 The Chair asked whether the decrease in job vacancy rates at Homerton Healthcare was mirrored at Barts Health. SD replied that within Barts Health it was quite mixed at the macro level but there was greater variation when you dive further down to the individual hospitals. An ongoing challenge was that it was easier to recruit to inner rather than outer London hospitals

5.10 The Chair thanked the Chair and Chief Execs for their reports and attendance and their kind offers of further items which would be scheduled.

RESOLVED:	**That the report and discussion be noted.**

6. Additional hospital discharge funding in north east London

6.1 The Chair stated that delayed discharges of care continue to be a key pressure on the local system and so he had asked NHS NEL to provide an overview of how the additional £200m (national figure) discharge fund announced in January was being spent as well as the previous £500m (national figure) 'winter pressures' funding which was now annual and so had an established process around its use.

6.2 He welcomed Clive Walsh (**CW)**, Director of Performance, NHS NEL.

6.3 Members gave consideration to the report: *Q4 22/23 Discharge Funding and 23/24-24/25 National Delivery Plan for Recovering urgent and Emergency Care Services.* CW took Members through the report in detail which covered: *£200m discharge funding for Q4 22/23; National Delivery Plan for Recovering Urgent and Emergency Services; 5 ambitions within the Plan; and Funding*

6.4 The Chair asked whether national guidance on this funding stream dictated what gets passported through to councils. CW replied that on NEL's share of the £600m they had identified how much they could usefully spend on step-down capacity. NHS NEL used £900k of £7.1m and remainder went to the 8 local authorities on a fair shares formula. On the new money (c.£600m) next year, c. £20m should come to NEL and 50% of that would go directly to local

authorities as early as possible in the next financial year. Use of the balance will be a discussion between NHS and councils via the Better Care Fund process. He added that there were national constraints on how the BCF money can be used.

6.5 The Chair asked what discussions were going on with councils on a long term strategy to sort out delayed discharges of care, such as building more local accommodation for step-down type solutions for adult social care to reduce the need for expensive residential placements. CW replied that those conversations were taking place at both ICS and Place level. One example was that they might use some of the money to look at the division of nursing and residential beds between inner and outer NEL to examine whether more capacity could be created in Inner. Historically this was a problem due to the comparative cost of land (inner vs outer) and the nature of the properties needed for residential care. ZE added that patterns do exist in north east London and everyone finds it difficult to find places especially for patients with dementia or 'behaviour which challenges'. They know there are gaps and in some cases where there are a relatively small number of places, the nature of the need and the local care market varies. It all needs to be looked at via a strong local lens. She added that the allocation of most of this money is via the BCF so the decision making is joint between local authorities and the NHS. There is a need to understand what overall demand and capacity is across particular footprints and unfortunately people will end up in out of borough placements when the system is under great pressure.

6.6 The Chair asked about the financial argument for 'invest to save' here and the gains to be had from patients not in residential care being able to claim their housing benefit, which would contribute to costs. Cllr Masters sought clarity on how the funding formula was applied. CW clarified the formula adding that competition may arise because of variations but Place leads and directors of Adult Services are involved in the details. ZE explained more about the two components of the funding. Around half of NELs share c. 14m went directly to local authorities and was allocated according to government funding criteria i.e. the standard formula similar to the Public Health grant, that funding formula does take account of the historic measures of deprivation. City and Hackney despite having a younger population got more under this measure. The remainder of the funding was distributed via NHS NEL and it was therefore decided to focus more on older people, because levels of deprivation had already been taken into account in the local authority funding allocation. They also looked at where delayed discharge needs varied and took account of the need to work across the ICS to make sure that a fair formula was applied and that all parties understood it. The additional January funding because it was rushed had to be decided on very quickly and they had to decide on it on the basis of what was going to work best in the circumstances, as there was a very short window in which that money could be spent.

6.7 Cllr Khan asked what processes were in place to ensure the funding is used for care packages. CW replied the usual ones. There were locality based groups

that involved the Place Directors and council staff and together they looked at and jointly planned the care pathways of the patients being discharged. He added that overall, although there was additional funding, it must be remembered it is in the context of significant funding constraints on local authorities and on the NHS and this had to be factored into it. At the end of March they will look at how many additional care packages they have made with this cash injection and do an assessment of additional flow through the hospitals and the impact of that funding and try and reconcile all of that.

6.8 Cllr Sweden asked whether the same constraints on this funding will apply next year; about provision of therapy input in step-down offer and about the need to upskill care staff. CW replied that they were already talking to councils and potential private or third sector providers of step-down care about what might be feasible and the lead times for that. They would like to increase the general provision of step down care because they noted that there may also be a suppressed demand within the hospitals. On therapy, the challenge is that there is a national shortage of both Physios and OTs and so the focus is trying to get them to work in NEL in order to better support the various reablement pathways they are trying to build. The Virtual Wards will also help with this. He added that they have a deficit in NEL in neuro rehabilitation and one focus in the coming year will be on expanding the amount and quality of neuro rehab and this will require high levels of therapy input. On upskilling care staff, he stated that there was a national discussion on how to retain care staff in the sector and enable them to gain greater skills and so better remuneration. ZE added that in two of the boroughs they were doing pilot work on training domiciliary care workers to do tasks that might otherwise be done by health professionals so that they can make additional payments to them and provide more integrated care and they wanted to share best practice on this.

6.9 Cllr Patrick suggested that the targets in the National Plan were not very ambitious. CW replied that this criticism had been widely expressed. In January the Category 2 ambulance response times in London had been better than in December but nevertheless ambulance strikes and the drop in volumes meant that the average in January was 38 mins. He added that it would take a long time to get that down to 30. On the '76% seen in ED' target, the Homerton had been fairly consistently achieving 80 to 85% and was at the upper range. The 76% target was going to be particularly challenging for hospitals. He stated he remembered the introduction of the 98% target and that had been brought in in a phased way over several years. There were 5 ambitions in the plan which they had discussed including on speeding up discharge and allocation of funding and on virtual wards. In March they would work up their response to the National Recovery Plan and that would be put in the public domain and he'd be happy to have a discussion on that if useful.

ACTION:	**NHS NELs response to the 'National Delivery Plan for Recovering Urgent and Emergency Services' be added to future work programme.**

ACTION:	**Director of Performance NHS NEL to share a note on the updated hospital discharge funding formula when available.**

6.10 Cllr Khan asked how NEL ICS determines how BCF money is distributed. CW replied that assuming the rules don't change and that NEL area receives c £20m for this next year, then £10m will go directly to local authorities and £10m through BCF and discussions between NHS and the councils at locality level will take place on how best to apply that. It is yet to be confirmed but it will be a joint decision making as part of the Better Care Fund process.

6.11 The Chair asked how NHS 111 might be improved and what the national intentions for it were. CW replied that it was re-iterated in the National Plan that patients be encouraged to contact 111 first to be guided but it was not fleshed out in detail. Many in Primary Care continue to be concerned about breaking the link between the patient and professionals who know the patient and their history best. He added that currently there was a lack of clarity about what the national intentions are around 111. In NEL they have an NHS111 contract with London Ambulance Service until July and they had agreed that it would be extended for a further two years until there is greater clarity on what the national intentions are.

6.12 Cllr Masters asked about the very poor satisfaction levels with NHS 111 in Newham. CW replied that satisfaction levels were poor both locally and nationally and they were doing a lot with LAS on how they could improve and looking at the possible model for the future. He explained that when it was introduced nationally they had certain expectations about volumes of calls however these have been greatly exceeded. So they have 'sized' the service in a different way to the actual volume of calls and there is a need to totally recast it to offer a better service to patients. He added that you can see the difficulties by looking at the number of abandoned calls, which remain very high.

6.13 The Chair stated that he would like the Committee to return to the issue of NHS 111 in a future meeting. He echoed Cllr Masters concerns re satisfaction levels adding that a key problem was that you can't speak to clinicians. There used to be an excellent bespoke service in City and Hackney and he added that it would be interesting to understand if there was greater scope locally to do some more bespoke commissioning and whether the model could be altered to put clinicians at the first point of context rather than a complex filtering system driven by an algorithm.

ACTION:	**'Improving the performance of NHS 111 across NEL' to be added to the work programme.**

6.14 The Chair thanked CW for his report and in-depth answers.

RESOLVED:	**That the report be noted.**

7. NEL Research and Engagement Network funding

7.1 The Chair stated that local research was a key part of the health system and research needed to be based on the cohorts which are as representative of the local communities as possible, if it is to have value. He stated that NEL ICS had secured £100k to support the development of a research engagement network for NEL and he had asked the lead for this to update Members on it.

7.2 He welcomed to the meeting: Dr Victoria Tzortziou Brown (**VB**) OBE (Research and Innovation Lead, North East London Health and Care Partnership)

7.3 Members gave consideration to a report '*NEL Research and Engagement Network Funding*' which outlined the context and included a short outline of the project activity and a note on outcomes and VB took Members through it in detail.

7.4 The Chair asked whether the end product would be the research itself or the new Network and how seldom heard groups could better be reached. VB replied that it was definitely the Network and that would in turn help them to reach out to underserved communities. Already certain areas were very active in engaging with research. They would focus on Newham and Barking & Dagenham as data showed under representation there and reduced participation compared to others.

7.5 Cllr Brewer asked about the extent of research focuing on Diabetes. VB explained that a lot of work was taking place on Diabetes and they had in fact chosen diabetes and obesity as test cases for this project in order to better understand the barriers to participation in research. A lot of the research on diabetes was driven by Secondary Care and they would like to change that and ensure that the research is driven instead by patients and service users, she added.

7.6 Cllr Masters asked for clarity on the findings and assumptions re LB Newham. VB explained that it was not that the VCS sector there wasn't active enough, it was that the right connections hadn't been made between those undertaking the research and those recruiting participants. The key was to use the local VCS as an important asset, she added.

7.7 Cllr Khan asked how the research will be used and what success would look like. VB replied that it would be that, in future, research was designed by service users and that more people from our diverse communities participated in it so that in the end we can be more confident that the research findings

achieved apply to the totality of our local population in north east London and not just the current numbers who participate.

7.8 The Chair thanked VB for her report and suggested that at an appropriate point in a year or so it might be useful to revisit this item and hear about how the project went and whether they were able to reach into parts of the community that couldn't do previously and what processes and methods they had used to achieve this so that there might be learning that could be shared with all the health and care partners.

ACTION:	**Update on outcomes of the NEL Research and Engagement Network to be added to the work programme for Feb/March 2024.**

RESOLVED:	**That the report and discussion be noted.**

8. Redevelopment of Whipps Cross - update from Chair of Whipps Cross JHOSC update

8.1 Cllr Sweden gave a verbal update on the work of the special JHOSC. He stated that they had last met on 12 Jan '23 when they had discussed 'End of Life Care' aspects. No clear vision of what would be proposed was yet available and officers were not yet ready to go out to any formal consultation on that aspect, he added.

8.2 The Committees work had been overtaken by events however in that they had been expecting confirmation of funding for preliminary building works at the site, a deadline on the announcement of that had been missed and then a government announcement was made that the national hospital building programme would not progress until 2025. Because of this work was now at a standstill and this was a very frustrating outcome. The Chair asked if all of the 40 projects had been stalled. Cllr Sweden replied that it had and even though Whipps Cross was in the top list of 12, the announcement covered all and was made in the context of the current economic difficulties.

8.3 The Chair stated that this was a very disappointing situation and he thanked Cllr Sweden and his colleagues for their efforts.

9. Minutes of previous meeting

9.1 Members gave consideration to the draft minutes for the meeting on 15 December 2022 and noted the matters arising..

RESOLVED:	**That the minutes of the meeting held on 15 Dec 2022 be agreed as a correct record and that the matters arising be noted.**

10. INEL JHOSC future work programme 2022/23

10.1 Members gave consideration to the updated work programme.

RESOLVED:	**That the updated work programme be noted.**

11. Any other business

11.1 The Chair stated that this would be his last meeting as Chair as the Chair of the Committee rotates between the boroughs and it would now move to LB Waltham Forest for two years. ZE thanked the Chair for the constructive debates he had led and thanked the O&S officer for his work. Members thanked the Chair and the Chair wished Cllrs Sweden or Deakin well as they take on leading the committee from the next meeting in June.

For the attention of members of the North East London Scrutiny Committees

Talking Therapies in the NE London ICB area

I am writing as a Tower Hamlets resident and a psy professional with decades of experience, to ask that you turn serious attention to the accessibility of talking therapy in our communities in the NE London ICB region.

There is a growing crisis, with ever-more people suffering from common mental health distress. At the same time, the NHS Long Term Plan includes promises to reorganise community mental health services. For both reasons, I suggest it is now time for a critical review of the primary care psychological therapies currently being provided by the NHS in the NE London boroughs.

In NE London, as elsewhere, NHS Talking Therapies (formerly known as Improving Access to Psychological Therapies, or IAPT[1]) has for many years been providing an inefficient and unsatisfactory service, supported in part by misleading statistical evidence of its efficacy. Historically, IAPT has not been subjected to independent audit, and its claim to provide a successful, innovative, adult mental health service is neither properly accountable and transparent, nor, in fact, evidence-based. I explain below how this plays out in NE London.

Talking therapy can definitely be brought closer and respond more flexibly to different communities in need of psychological and emotional support. But, to achieve this, the monopoly of NHS Talking Therapies (NHS TT) in primary care will have to be undone. I have set out some of the alternatives in this paper.

1. NHS Talking Therapies meets none of its NHS targets

The NHS Long Term Plan gives Talking Therapies (TT) three targets: on access, waiting times and recovery.[2]

- It is asked to give access to 25% of the 'adult community prevalence' of common mental health disorders (CMD).
- 75% of referrals should have their first treatment session within six weeks.
- 50% of its patients should recover.

It does none of these.

- The adult community prevalence of CMD in the NE London ICB area is around 320,000 people.[3] IAPT gave access to 48,800 adults in 2021-22, i.e. just over 15% of the prevalence – well below the 25% target. Only about half of the 15% 'recovered'.
- IAPT in NE London apparently met the waiting time target in 2021-22, but achieved this by calling the assessment session the first session. About half of all referrals dropped out after this one session. Of the remainder, half waited between 6 to 12+ weeks for their second session.[4]
- The claimed recovery rate of 50% applies to people who *finished* rather than *entered* a course of treatment. The recovery rate[5] of people who *entered* therapy was 25% in 2021-22. There is also virtually no follow up after treatment to find out whether recovery lasts for any length of time. In NE London, 1% of referrals who finished therapy were followed up after 6 months.[6] There are reports of NHS TT staff nationally being pressured by management to falsify their outcome statistics.[7]

2. NHS Talking Therapies is not cost-effective

The cost of NHS TT sessions is not in the public domain, as far as I have been able to discover. But we can do a very crude calculation.

In 2021-22, IAPT funding for NE London was £36.2 million. The median duration of a session that year was 52 minutes, and for a finished course of treatment it was 310 minutes or 6 sessions. If we divide the spend by the number of people who finished a course of treatment (25,275), the cost per session was just under £240.[8]

If we use this admittedly crude measure, NHS TT's claim to cost efficiency doesn't hold water. In the Counselling Directory[9] (the largest directory of independent practitioners in UK), over 60 qualified, self-employed, insured and professionally accountable independent practitioners based in east London are currently offering counselling and psychotherapy for under £40 per session.[10] Even allowing for NHS TT's high drop-out rate of 50% of clients who started therapy, £240 could potentially buy for each patient at least three times the number of sessions.

3. NHS Talking Therapies has an exceptionally high drop-out rate

Why did only 25,275 out of 72,000 referrals in 2021-22 finish a course of IAPT therapy in NE London? What happened to the other 65% of our residents who, for one reason or another, had expressed concern about their mental health?

According to their annual performance data, IAPT services in NE London are more or less average for England as a whole.[11] But, by any comparisons, the dropout rates are exceptionally high.[12]

So, what is the problem with NHS TT?

4. One size doesn't fit all – the denial of care

NHS TT is a political and ideological project. It is organised around variations of a single psychological theory and practice – cognitive behavioural therapy (CBT). For NHS TT, CBT has been adapted to the requirements of New Public Management in terms of measurable costs and targets, standardisation of practice and data collection, efficient through-put and the prioritisation of utilitarian values.

It has virtually exclusive approval by NICE as evidence-based psychological therapy provision – a status which has been challenged consistently as manufactured and politically protected.[13] Shortly after its introduction in 2008, it supplanted most other counselling and psychotherapy provision in primary care.

Many therapists who are not part of the NHS TT workforce do not recognise its practice as "real" psychotherapy and counselling, in that it does not base itself in the co-creation of a therapeutic relationship and alliance. In many ways, NHS TT offers a technique rather than a relationship; a didactic rather than a therapeutic process.[14] Patients are "told" how to think.

NHS CBT is a model of therapy[15] that certainly helps a proportion of clients with distressing spirals of negative thinking and behaviour. It can be transforming to feel heard, to have the experience recognised and put into words, to have our emotional world taken seriously. For many people it will be their first experience of any kind therapeutic attention. This, in itself, is an admirable achievement of scale by the NHS TT project.

But, for many people and for all kinds of reasons, the NHS TT approach to emotional distress will either not make a connection, or will fail to travel deeply enough to carry meaning for the client. Dropping out is a fact of life for all therapy work, of course, but NHS TT's lack of relational flexibility, the rigidity of its commitment to an instrumental "assembly line" methodology[16] and its strict adherence to very short-term work[17] puts significant limits on the number of clients who will

engage and find it helpful.[18] Moreover, the NHS TT workforce nationally is itself suffering mental health problems under the pressure of delivering "assembly line" therapy.[19]

The service's monopoly over psychological therapies in the NHS is not based on patient care. In fact, in this period of increasing privatisation and monetisation of health care, it appears to be a forerunner of the politics of *denial* of care via the rhetoric of data, efficiency and social management.

5. NHS Talking Therapies fail to address inequalities of mental health care

The dominance of NHS TT is an obstacle to responding more effectively to common mental ill-health in our diverse communities.[20] The limitations of the service's standardised approach are demonstrated, for example, in its limited engagement with mental health inequalities around social deprivation, race and gender.

For example, 72% of *less* socially deprived referrals who entered therapy in NE London in 2021-22 finished a course of treatment, and 38% recovered. Among more deprived referrals, only 57% completed course of therapy and only 26% recovered. Barking and Dagenham, Hackney, Tower Hamlets and Newham are among the most deprived boroughs in London.[21] In Tower Hamlets, in 2019-20, only 18% of the more socially deprived who entered therapy recovered.[22]

Far more women than men access the service. In 2021-22, 70% of all referrals in NE London and 80% of people who finished a course of therapy were women.

Inequalities of access by ethnicity are striking. My home patch in Tower Hamlets has the largest Bangladeshi population in the UK. Comparing referrals from the Bangladeshi and the white communities in NE London, 36% of all Bangladeshi referrals dropped out before starting any therapy, 47% who did start went on to finish a course of treatment, and only 20% who entered therapy achieved recovery. The same figures for the white population were 28% initial dropout, 54% finished, and 29% recovered.

NE London CCG 2021-22	Total Referrals	Entered Therapy	Finished Therapy	Recovered	% of all referrals who finished	% of all referrals who recovered	% of referrals who started therapy and recovered	
White	33745	24365	13125	7130	39	21	29	
Black Caribbean	3605	2490	1230	645	34	18	26	
All Asian	15930	10860	5510	2485	35	16	23	
Bangladeshi	6655	4295	2010	865	30	13	20	

6. Talking therapy and rethinking community mental health

The NHS's Community Mental Health Framework for Adults and Older Adults (2019-21)[23] is an ambitious report, promising integrated care in local communities for people suffering severe and common mental health difficulties. But anyone who has been involved with NHS mental health services or who has been campaigning over the years to resist the process of privatisation,

outsourcing, defunding, digitalisation and staff reduction will know that we are in a political environment that will not support most of the Framework's ambitions with the funding and staffing it requires.[24]

Whatever does end up being introduced will almost certainly see the existing NHS TT service being tasked with delivering most of the promised "innovative", "integrated", "effective" care. But what does this mean in practice? In fact, NHS TT is highly privatised and heavily dependent on computerised self-help guides and wellbeing apps. It rations access to its services by using diagnostic algorithms and "clusters of unsuitability". It gives its therapists AI-determined optimal scripts for use with patients.[25] It is one of the few health services that has expanded steadily year on year since its beginnings in 2008.

None of this offers the best way to reach people in distress in our communities. Before yet more money is spent on our local NHS TT service, it needs to be subjected to thorough independent audit. At the moment, it represents an unacceptable waste of resources, while being presented as the only efficient contender in the provision of therapy for common mental health disorders.

Very many psy professionals believe that NHS TT's approach is neither efficient nor the only contender. There are genuine, viable alternatives that are more likely to help build networks of supportive relationship in local communities.

7. We need diversity of talking therapies

There are many free and low-cost therapy providers in London, run by fully qualified counsellors and psychotherapists, that serve their local community. They are often charities whose funding is limited and precarious.[26] There are also qualified therapists providing therapy and therapeutically-informed support in many community projects.

For example, I have been working for 4 years offering free psychotherapy at my local community centre in Poplar. I am doing individual weekly sessions with an open-ended relational approach. Many of my clients have chronic mental health difficulties but no therapeutic support from local services. I am developing emotional support groups for local residents and a reflective practice group for community workers who are feeling overwhelmed by referrals from GP social prescribing – a Common Mental Health Framework strategy. I have been approached by a local primary school to start a support group for its parents.

I am a founding member of the Free Psychotherapy Network.[27] Many FPN therapists have similar local arrangements with community projects. Our members are involved in a therapy centre at an urban farm in Hackney, free counselling in community centres in Ilford, therapy and emotional support with the homeless and substance misusers in Waltham Forest, work with primary schools and a parent/infant support service in Leytonstone, and a dozen charities offering low-cost counselling in NE London. The picture is similar in other parts of London and the UK generally. At the moment, these projects are small and have minimal funding. With the right support they and projects like them could grow rapidly.

Scores of experienced counsellor and psychotherapist colleagues are interested in working for the common good in community settings, but, unlike me, they cannot all afford to work without funding. Rather than focussing exclusively on funding the expansion of NHS TT with all its limitations, why can we not develop more imaginative and flexible initiatives at a far lower

sessional rate? These initiatives could include providing individual and group therapy in community centres, schools and colleges, as well as acting as support workers for residents and the communities around them. The practitioners involved would organise their own supervisory practice and shared peer reflection, make relationships with adult and young people's mental health care services, community project teams, local schools, GP practices and social prescribers, substance misuse services, homeless groups, and so on.

This kind of model puts therapists much closer to the everyday lives and needs of people, are more open to negotiating those needs *with* communities and can be an integral part of a bespoke range of ongoing resources and support.

New funding would be great. But there is also money in the system that can be repurposed. We already know of a low-cost counselling service in the Newcastle area that is being partially funded by Primary Care Network social prescribing budgets to provide more relational counselling for clients defined as "unsuitable" by the local NHS TT services. There is even more potential for lasting change if a proportion of local NHS funding that is currently going to our homogenised TT services could be redirected towards the community to deliver on the promises in the Long Term Plan. These NHS budgets could be held by Primary Care Networks, or by individual GP surgeries (who often employed counsellors before the introduction of IAPT) – bringing funding as close as possible to the communities that need to be served.

If the Common Mental Health Framework is to mean anything other than a smoke-screen of words and tech, the role of employed professionals, and their energy for making relationships of different kinds, has to be massively scaled up. Apps and social prescribing to already overloaded and under-funded charities and local authority services is not going to lift our communities out of the mental health crisis we are in. People and relationships built on trust over time are central to any substantive change in the emotional wellbeing of our NE London communities.

8. Audit and scrutiny

NHS TT is regularly praised by its leadership as a major national and international success story.[28] However, it is not independently audited and relies on the avalanche of its own data collecting to justify and maintain its claims to be a successful, evidence-based service. Many critical reviews of its data suggest a different picture.[29] In terms of its access rate, its drop-out rate and its recovery rate, its performance is poor, and far from cost-effective.[30] As far as the quality of the therapy it provides is concerned, there is no evidence that any positive therapeutic benefit is effective over time. Nor is there any evidence that the prevalence of common mental health problems in the UK population has declined in the decade since the service was rolled out – on the contrary.[31]

I am asking you as members of Scrutiny, Health and Wellbeing, and Healthwatch Committees to give serious consideration to the reality of failings and inefficiencies hiding in plain sight in the spreadsheets of NHS TT reports. In the middle of what seems to be an ever-deepening crisis of mental health, with so much political pressure for cuts in NHS services and staff, and in particular the decades of underfunding and denial of care in mental health care, it is time to attend with the utmost urgency to the need for dramatic improvements in the services available to our residents in North East London.

I look forward to a response from your committee.

Paul Atkinson

Professional Member of the Philadelphia Association

Member of Socialist Health Association/Keep Our NHS Public London Mental Health Group

Member of the Free Psychotherapy Network

[1] Where I refer to the data reports for NHS Talking Therapies before the name change in Feb 2023, I will use the term IAPT.

[2] https://mentalhealthwatch.rcpsych.ac.uk/local-area-reports/detail/north-east-london

https://www.england.nhs.uk/wp-content/uploads/2018/06/the-iapt-manual-v5.pdf pp 36-40

[3] Population of NE London ICS - 2,000,000; adult population = 1,600,00; adult prevalence of common mental health disorders @20% = 320,000 (see https://fingertips.phe.org.uk/profile/common-mental-disorders/area-search-results/E39000018?place_name=London&search_type=list-child-areas); NHS TT target is to give access to 25% of the adult prevalence of common mental health disorders = 80,000.

[4] https://www.bacp.co.uk/news/news-from-bacp/2019/5-december-long-waiting-times-for-iapt-unacceptable/ https://www.nationalworld.com/health/england-hidden-mental-health-crisis-wait-months-nhs-therapy-sessions-3875434?__hstc=219909318.abdfd074877621a20b7f26fee12df51e.1681230494976.1681230494976.1681230494976.1&__hssc=219909318.1.1681230494977&__hsfp=2568952849

[5] The definition of "recovery" and the way it is quantified by getting the client to complete a Beck inventory in every session, is a good example of the way the IAPT model has been mechanised.

[6] Some providers' follow-up to Freedom of Information requests is also non-existent https://www.whatdotheyknow.com/request/following_up_referral_drop_outs#incoming-2084534

[7] https://hrnews.co.uk/nhs-therapists-are-pressured-to-exaggerate-success/

[8] £36.2m/25,275/6 = £238.7 For median duration stats see https://app.powerbi.com/view?r=eyJrIjoiMDk2OWUzMjEtN2YxYS00YzgwLThkMGMtMjNlZWE1MWIyMTk3IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9 p.32

[9] https://www.counselling-directory.org.uk/search.php?search=East%20London&distance=5&session_type%5B%5D=in-person&session_type%5B%5D=online&business_type%5Bindividual%5D=on&price_min=40&price_max=40

[10] Psychological Wellbeing Practitioners (PWP) who do most of the Low Intensity work in NHS TT have a salary of between £14 and £17 per hour – https://www.prospects.ac.uk/job-profiles/psychological-wellbeing-practitioner

[11] See the March 2023 House of Commons Report for a good national overview of IAPT services – https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf

[12] In my 40-year experience practising counselling and psychotherapy in independent settings, the drop out rate for more relational therapies, rather than the instrumentalism of IAPT, is likely to be closer to 10%. However, studies of dropout rates in different settings and environments of mental health services are complex and vary. By any comparisons, IAPT dropout rates are exceptionally high – see https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-019-2235-z, https://cpe.psychopen.eu/index.php/cpe/article/view/6695/6695.html, https://onlinelibrary.wiley.com/doi/abs/10.1002/capr.12249, https://iaptus.co.uk/2022/06/what-impacts-patient-engagement-with-mental-health-treatment/

[13] http://www.limbus.org.uk/cbt/index.html

[14] https://www.bmj.com/content/380/bmj.p464

[15] https://www.england.nhs.uk/wp-content/uploads/2018/06/the-nhs-talking-therapies-manual-v6.pdf p.13. In NE London ICB in 2021-22, there were 9920 finished courses of CBT; 6365 of guided self-help (book); 1835 counselling for depression; 1365 non-guided self-help (book); and a small number of other types of therapy - see https://app.powerbi.com/view?r=eyJrIjoiOTIyYTgyYjEtM2QxZS00YzYyLWI3YTEtZDU1NjhjNjlmYmE0IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9 p.4.

[16] https://www.pccs-books.co.uk/articles/article/the-industrialisation-of-care-counselling-psychotherapy-and-the-impact-of-i

[17] This therapist can simply not understand how, in many cases, "courses of treatment" consist of just two sessions.

[18] https://bpspsychub.onlinelibrary.wiley.com/doi/10.1111/bjc.12314

[19] https://www.rcpsych.ac.uk/docs/default-source/events/faculties-and-sigs/general-adult-psychiatry-20/research-case-reports/abeku-koomson.pdf?sfvrsn=76850f44_2#:~:text=Amongst%20the%20IAPT%20workforce%2C%20PWPs,in%20the%20mental%20health%20field2.

[20] Its influence is not confined to NHS services. Its model of therapy practice has been imposed on most charitable therapy provision that relies on public and charitable funding. MIND and other major mental health charities have, in fact, become NHS-approved IAPT providers.

[21] https://centreforlondon.org/blog/deprivation-london/

[22] https://www.health.org.uk/news-and-comment/charts-and-infographics/referrals-for-psychological-therapy-from-patients-in-deprive

[23] https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/the-community-mental-health-framework-for-adults-and-older-adults-full-guidance/part-1-the-community-mental-health-framework-for-adults-and-older-adults---support-care-and-treatment---nccmh---march-2021.pdf

or https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

[24] For example, Prof Peter Fonagy, UCL and NE London ICB partner, recently wrote: "A continuing challenge lies within resources – it is estimated that if every psychologist worked 50 hours a week they would still only meet 12% of the current demand." https://uclpartners.com/blog-post/meeting-mental-health-needs-with-innovation-and-connection/

[25] https://www.lyssn.io/press-release_trent-pts/

[26] https://freepsychotherapynetwork.com/organisations-offering-low-cost-psychotherapy/

[27] https://freepsychotherapynetwork.com/

[28] https://www.england.nhs.uk/blog/iapt-at-10-achievements-and-challenges/

https://www.google.com/search?client=safari&rls=en&q=ny+times+iapt&ie=UTF-8&oe=UTF-8

[29] http://www.cbtwatch.com/clinical-commissioning-groups-ccgs-incredibly-naive-re-iapt/

https://novaramedia.com/2020/02/17/marketising-the-mental-health-crisis-how-the-cbt-empire-builders-colonised-the-nhs/

[30] See NE London ICB report p.12 - https://northeastlondon.icb.nhs.uk/wp-content/uploads/2022/07/Annual_Report_2021-22_FINAL_Redacted.pdf

[31] http://www.cbtwatch.com/more-treatment-but-no-less-disorder-what-is-going-on-here/ Compare 2007,2014,2017 - https://app.powerbi.com/view?r=eyJrIjoiMmRiY2FkYmUtZDQwOS00MDNlLWEyYTktZTQ1N2RiZTNkNGM5IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9 and https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data

North East London Health & Care Partnership

NELFT NHS Foundation Trust

The North East London Mental Health, Learning Disability and Autism Collaborative

12 July 2023

NHS North East London

NHS East London NHS Foundation Trust

Introduction to the Mental Health Learning Disability and Autism Collaborative

- The North East London Mental Health, learning Disability and Autism Collaborative is a partnership between **NEL ICB, ELFT, NELFT,** and the **seven place-based partnerships** in close collaboration with service users and carers, communities, local authorities, primary care, the voluntary and community sector and other services.

- The **aim** of the 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.

Service users and carers across NEL co-designed this image as a way to help describe the collaborative

Adult mental health service user priorities

- We have worked together through the NEL MHLDA Collaborative to support lived experience leaders to design and facilitate a NEL mental health summit in September 2022 to define the priorities for the NEL Integrated Care Strategy. The **seven priorities identified by service users and carers** are now front and centre in the NEL Integrated Care Strategy and Joint Forward Plan.

- We have **championed lived experience leadership** as key members of the NEL MHLDA Collaborative Committee. We have now formally recruited four lived experience leaders to be members of the Committee, alongside three deputies. We are the only Collaborative or place-based Committee to have such extensive lived experience leadership baked into our governance in NEL, and perhaps in the country.

- We have a long way to go, but our championing of lived experience leadership and people participation in everything we do would simply not have been possible without NELFT and ELFT working together

1. **Put what matters to service users and carers front and centre** so that people with lived experience of mental health conditions have an improved quality of life, with joined-up support around the social determinants of health
2. **Enable and support lived experience leadership** at every level in the system so that service users and carers are equally valued for their leadership skills and experience as clinicians, commissioners and other professionals
3. **Embed and standardise our approach to peer support across NEL** 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
4. **Improve cultural awareness and cultural competence** across NEL 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
5. **Providing more and better support to carers** so they feel better cared for themselves, more confident and able to care for others, and are valued for the knowledge and insights they can bring
6. **Improve people's experience of accessing mental health services**, including people's first contact with mental health services, reducing inequality of access and improving the quality of communication and support during key points of transition
7. **Understand and act upon local priorities for mental health,** through data and engagement with communities to understand the needs, assets, wishes and aspirations of our borough populations, and the unmet needs and inequalities facing specific groups

Children and young peoples' mental health service user priorities

Fairness - "I want the same chances at life as my peers no matter how difficult my journey has been"

Coproduction - "I want to be actively engaged and supported to get involved and see changes that I have influenced"

Equality - "I want the same experience of care and range of support regardless of where I live or go to school"

Joined up care - "I want professionals to work together so that I tell my story once and be involved in deciding what support will suit me and my family's goals and needs"

Easy access to services - "I want to be able to see all support available to me, my family and friends in one place"

Different types of help - "I want to access support in different ways that suits me and my goals, including helping me to recognise the early signs of an issue"

People who help me - "I want to be able to access different support from different people, including those with lived experience, when and where I need it"

Big changes in my life - "I want to feel like professionals care as I move between different stages of my life"

Language - "I want professionals to use language that makes sense to me, and stop the acronyms!"

Culture - "I want professionals to know about my culture and to respect my culture"

Choice, control and support - "I want to be able to decide how my family are involved in my support, and they might also need support"

- Through a series of coproduction events with children and young people (CYP) and carers called **All About Me for the Benefit of Everyone**, young people have identified a set of clear priorities for health and care services, and have defined the outcomes they wish to achieve (see above).

- The latest event, held on the 29 April 2023 at the London Stadium, asked CYP how they want to be involved in leading change in mental health services. Overwhelmingly, CYP told us that they want to participate actively in improvement projects and initiatives, and not just act in an advisory capacity. Our first coproduction steering group met on 8 June 2023 to identify clear opportunities for CYP to get involved.

Working collaboratively across the system and within places

The North-East London Mental Health Learning Disability & Autism Collaborative structure includes:

- A joint committee of the ICB, NELFT and ELFT, carrying responsibility for the functions associated with the Mental Health Investment Standard, and other NHS mental health and learning disability & autism funding, with accountability to deliver the NHS Long Term Plan, with delegated responsibilities from the ICB and the two trusts

- Supported by an MHLDA Collaborative Programme Board and Executive Group, which will bring executives from partners together to lead, develop and deliver the Collaborative programme, with a PMO in place to coordinate key functions

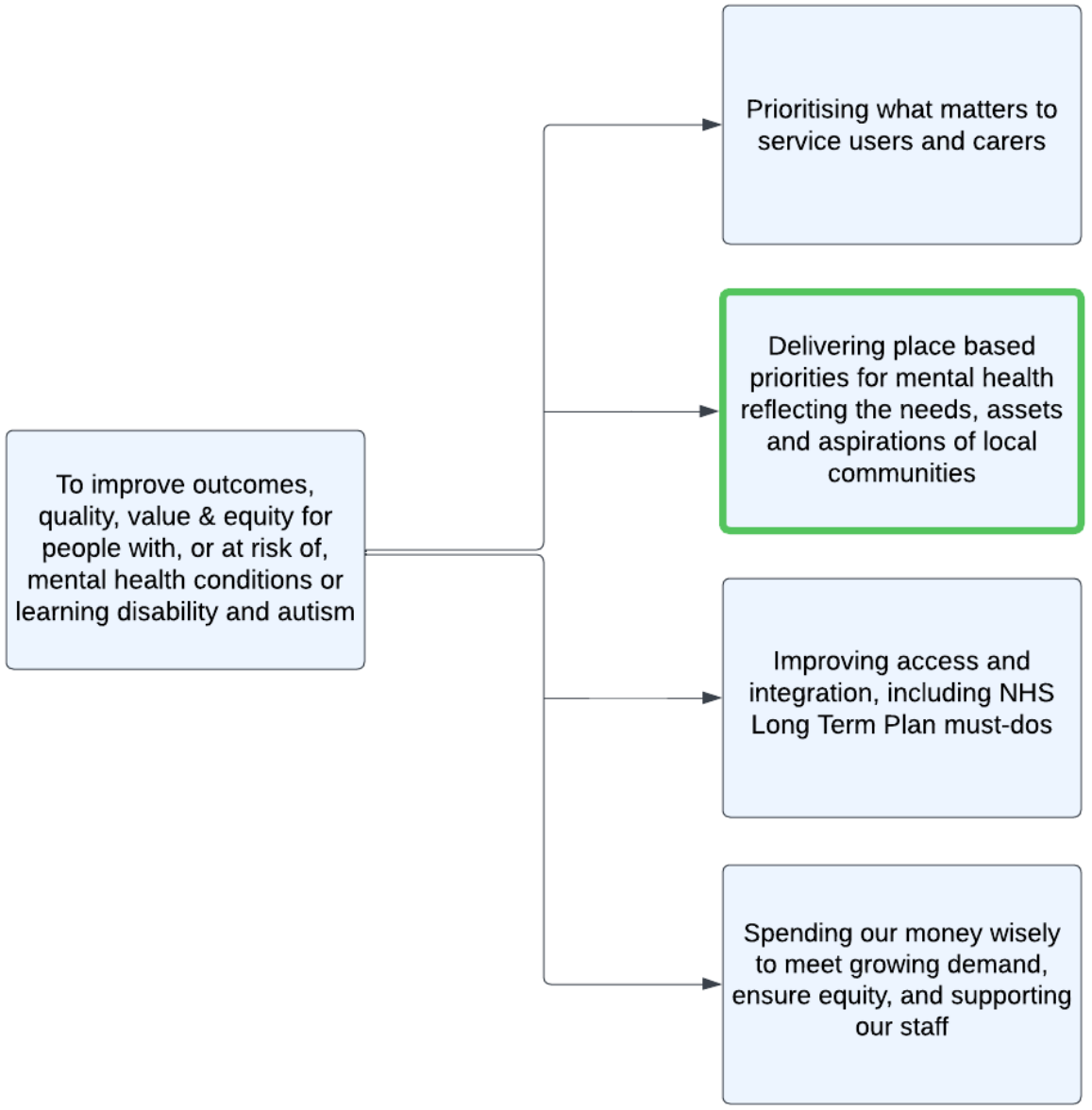
- Working with **place based mental health partnerships**: within NEL wide allocation and planning and delivery parameters established by the Joint Committee, we will work with place-based partners on developing and delivering place-based priorities, informed by a deep understanding of the needs and assets of the local population, and local priorities established by the Health & Wellbeing Board and borough-based executive, including public mental health and tackling health inequalities

- Improvement networks/learning systems (see next slide)

The MHLDA Collaborative approach is purposefully designed to have a horizonal dimension – working across the seven places in NEL where required – and a vertical dimension – working into and out of places where required.

Connection into the other NEL collaboratives is also key – through the place based leadership committees, the ICB Population Health & Integration Committee, and the improvement networks led by both the MHLDA Collaborative (e.g. physical health of people with SMI) and other collaboratives (e.g. maternity).

The MLDA Collaborative Strategy has four main elements:



Improvement networks

- We are **bringing clinical leads and social care professionals together with service users and carers** from across the two Trusts, primary care, and other partners around key improvement priorities across North East London. These include:

- **Primary care talking therapies (or "IAPT"):** our clinical leads across the two Trusts and the Homerton are working together to share learning and develop our services. On 3rd March they held an improvement network away day event, attended by members from all of our teams across the whole of NEL – it was a warm and joyful event, with a deep sense of collaboration and some very creative and thoughtful ideas on how we can collaborate more deeply across our services to promote better outcomes, access and equity. Some of these ideas are now already taking shape – for example the network is intending to launch **our first NEL wide in-person group therapies** for residents facilitated by our Bengali and Albanian staff in Bengali and Albanian in the early Summer.

- **Children & young peoples mental health:** Our children and young people's mental health improvement network is also progressing well. On 29th April the network organised a co-production workshop with 40 children and young people and their families to develop our priorities and design our approach for lived experience leadership.

- We are now in the process of launching improvement networks for **perinatal mental health**, **dementia** and **rehabilitation**.

- **Our improvement networks are generating real energy**. They are:
  - ❑ Wherever possible being organized around identifiable populations (rather than services).
  - ❑ Understanding need, assets, demand, outcomes, quality and value, including inequalities.
  - ❑ Focusing on improvement, sharing learning and deploying where appropriate triple aim/quality improvement.
  - ❑ Being led by a lead clinician, along with a service user leader, with identified management support – a triumvirate leadership approach.
  - ❑ Linking to other NEL programmes, including the primary care collaborative, acute collaborative, children and young people's programme.

Planning together for 2023/24

- We have **collaborated more deeply than ever before** in developing our operating plans for mental health, learning disability & autism for 2023/24, developing together plans that see c. £27m new investment into mental health and £4.4m into learning disability & autism
- The plan has led to c. £14.5m new mental health funding and £2.4m of learning disability & autism funding to services in Barking & Dagenham, Havering, Redbridge and Waltham Forest and c. £12.5m and £1.9m of learning disability & autism funding to City & Hackney, Newham and Tower Hamlets
- The plan has **explicitly recognised inequalities/variation in funding across our seven boroughs**. This is something that the Collaborative is uniquely placed to do, given it involves the two Trusts working together to plan with the knowledge of variation across boroughs from our clinical and service user experts, and the ability to influence/determine how money is allocated through our partnership director leads. For **CAMHS funding in particular**, we have been able to recognise under-investment in Barking & Dagenham, Newham, Redbridge and Waltham Forest and invest more heavily in those places.
- The plan has also explicitly recognised urgent & emergency care pressures in outer boroughs and **recurrently funded the Goodmayes Clinical Decision Unit and the community crisis services**
- We have also secured **c.£1.5m capital investment** into our urgent & emergency care services for 2023/24
- **None of the above would have been achievable** if the Collaborative had not been in place with our leadership teams across NELFT and ELFT working very closely together.

Urgent and Emergency Care (UEC)

- We have experienced **considerable and sustained pressures** in urgent & emergency care services over the last twelve months, in particular people with mental health conditions attending A&E departments and waiting for a long time for care to be put in place for appropriate discharge, including inpatient beds.
- The reasons for this are complex, but include growing complexity in the problems people are experiencing, in the context of the pandemic. The particular pressure on A&E departments includes, but is not limited to, people with mental health conditions – in fact the number of people with mental health conditions attending A&E with mental health as the primary issue is proportionately very small, however we are absolutely **committed to ensuring people with mental health conditions do not have to wait a long time in A&E**.
- Together across NELFT and ELFT we are working together to develop and implement our plans to ensure this is the case:
  - Working together to manage beds across North East London, with NELFT and ELFT **providing beds to each other when available** and necessary, so we do not have to use the private sector or place people out of area.
  - Undertaken an audit of people waiting longer than 12 hours in all of our A&E departments and we are w**orking across psychiatric liaison and A&E teams to improve A&E care processes**, with a NEL-wide event planned in June to bring all of our teams together.
  - Planning to open up **additional patient capacity at Goodmayes** later this year.
  - Providing **local female psychiatric intensive care beds for NELFT service users** at Rosebank Ward, Mile End Hospital (up until this year, all NELFT service users requiring female PICU were admitted to the private sector).
  - Planning to invest in and develop our **Health Based Places of Safety**, opening up an additional room at Sunflower Court later in the year.
  - Planning to invest in our **psychiatric liaison teams**, following on from a review which is currently underway.
  - Planning to invest in and develop our **crisis line services** in readiness for a new service to be in place early next year.

Deriving insights from data: system diagnostic for MHLDA

- We are currently undertaking a “diagnostic” of mental health, learning disability & autism across north east London

- The purpose of the diagnostic is to support the North East London Mental Health, Learning Disability and Autism Collaborative to develop a clear understanding of the outcomes and quality and value we achieve in our MHLDA programmes for the money we spend

- The intention is that the diagnostic will:
  - ✓ Help the system to understand the need for mental health, learning disability and autism services, including the relative complexity of need across places, unmet needs, inequities in access and outcomes, and likely future demand
  - ✓ Cover all ages
  - ✓ Create a compelling evidence base to underpin future plans
  - ✓ Support sustainability of services
  - ✓ Support a fair allocation of system resources
  - ✓ Provide a common planning framework and tool for ongoing use

- An expert supplier (PA Consulting) has been secured to support the diagnostic, with contract commencement in January 2023, and project completion expected in autumn 2023.

Our analytical framework will seek to answer high level strategic questions, whilst providing service-level insights

		System-level output	Service-level output	Insights and recommendations
Equity and Funding	Is money being spent equitably across boroughs and services?	A review of current system allocation taking into account population need	Where services are receiving higher or lower levels of funding compared to current need	• Recommendations on reallocation of funds
Value and Best Practice	Are we achieving the best outcomes based on spend?	Overview of areas of the system achieving the best outcomes	A view of services delivering the optimal outcomes	• Recommendations for future service models
Demand and Capacity	Where are the biggest demand pressures and where does demand exceed capacity?	Understanding of areas with growing demand, workforce / finance capacity constraints	A view on fragile services where demand will exceed capacity	• Recommendations on reallocation of funds
Equality of Access	Are services currently equal in access and availability for different cohorts across and within boroughs?	A review of protected characteristics and areas where there is inequality of access.	Understanding where services have the highest inequalities	• Recommendations for new/different services

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North East London Health & Care Partnership

Community Collaborative

Overview Highlight Report

June 2023

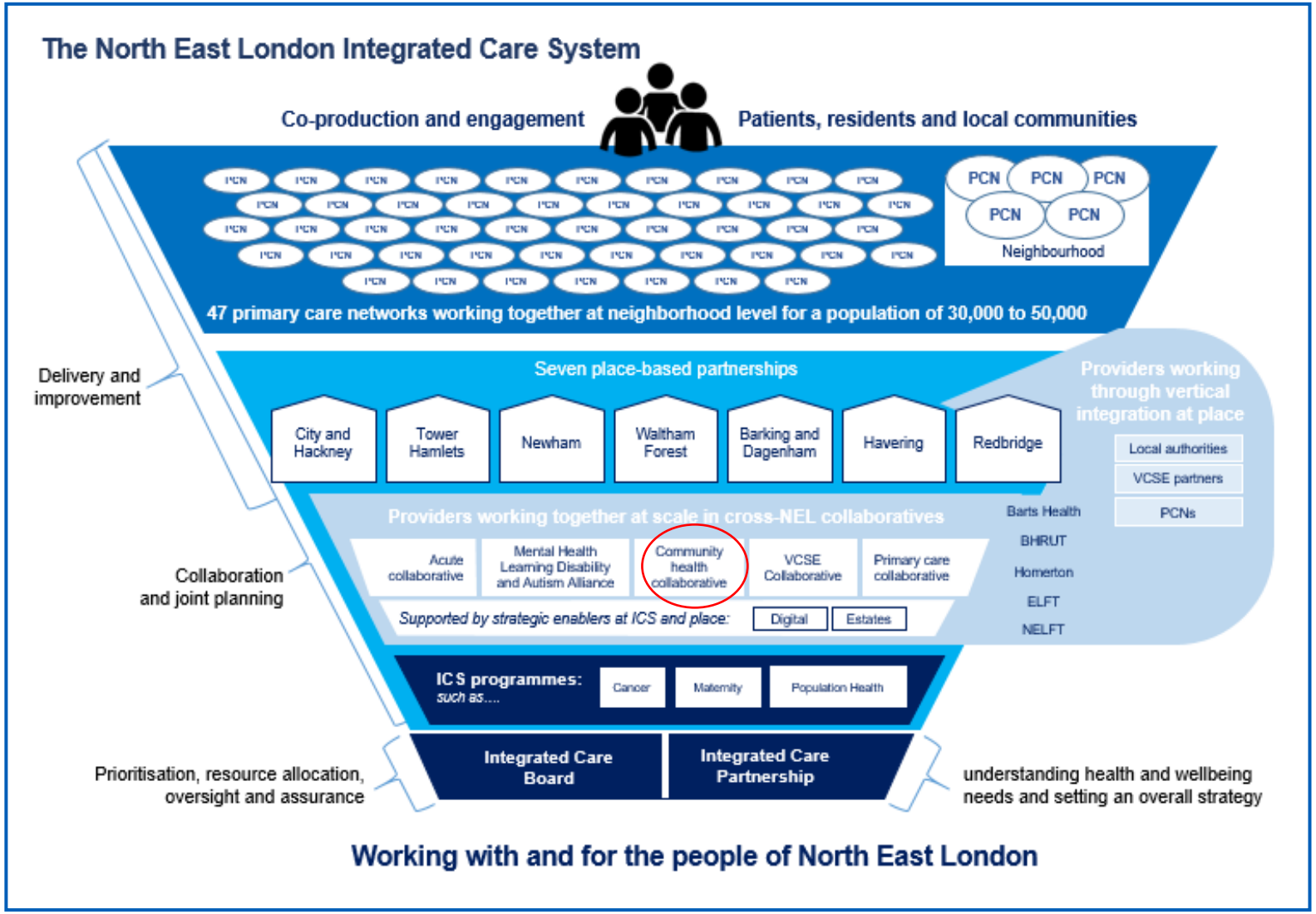
Sally Adams - Director for the Community Collaborative Programme

NEL Context Community Collaborative

NEL Community Collaborative sits alongside four other NEL collaboratives (acute care, primary care, mental health, and Voluntary Community Social Enterprises (VCSE) organisations) within NEL's integrated care system.

The collaboratives will work at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:

- reduce unwarranted variation and inequality in health outcomes, access to services and experience; and
- improve resilience by, for example, providing mutual aid.



NEL Community Collaborative Purpose

Operating Plan deliverables

- The Community Collaborative is a collaboration of Providers including system NHS Community Provider, Voluntary Sector, Clinical Leads etc. to tackle and deliver services to address inequalities in the community.

- The Community Collaborative has been established to support a partnership approach to reducing variation in community health services, and identify opportunities to share learning across partners alongside other system-wide ambitions.

- The main focus of Community Collaborative is also to improve system resilience.

- By taking a partnership approach, we have agreed on the principles, initial workplan and strategic aims for the collaborative and are now transitioning from development to implementation of the operating model for the NEL Community Collaborative. Workshops have taken place with providers to explore key principles.

- The current community programme of work has evolved, and throughout its developmental phase, there has been a continuation of key programmes e.g. Virtual wards, long covid recovery, urgent community response, community waiting lists baselines and other aspects of the Community Health Service (CHS) national operating plan.

- The Collaborative Programme Board (CPB) directly oversees a number of projects and programmes within Community Healthcare in North East London. Of these projects reporting into CPB, some form a programme of work that is managed or delivered directly by NEL-wide ICB staff resources whilst others are delivered within Place with ICB resources reporting on this work either within NEL or to NHSE. The Board reports into a Collaborative Steering Committee where key strategic decisions are made in partnership with ICS leads.

Principles

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

The primary relationship of Community Health Service (CHS) Providers is with “Place”:

- In the NEL context this means place level
- This reflects the model of service delivery, which is in a patient’s own home or very close to it and which requires close collaboration with acute care, primary care, social care and children's’ services

Collaboration across all CHS providers at an ICS level should be focused on:

- Areas where there are clear population health needs that are best supported at an ICS or multi-borough level, including multi-borough work with local authority partners where agreed with partners
- Achieving common standards (agreed with partners) to reduce unwarranted variations and address inequalities in health outcomes, access to services and experience, this would include advice and encouragement to adopt effective digital technologies
- Improving resilience by, for example, providing mutual aid to support fragile services

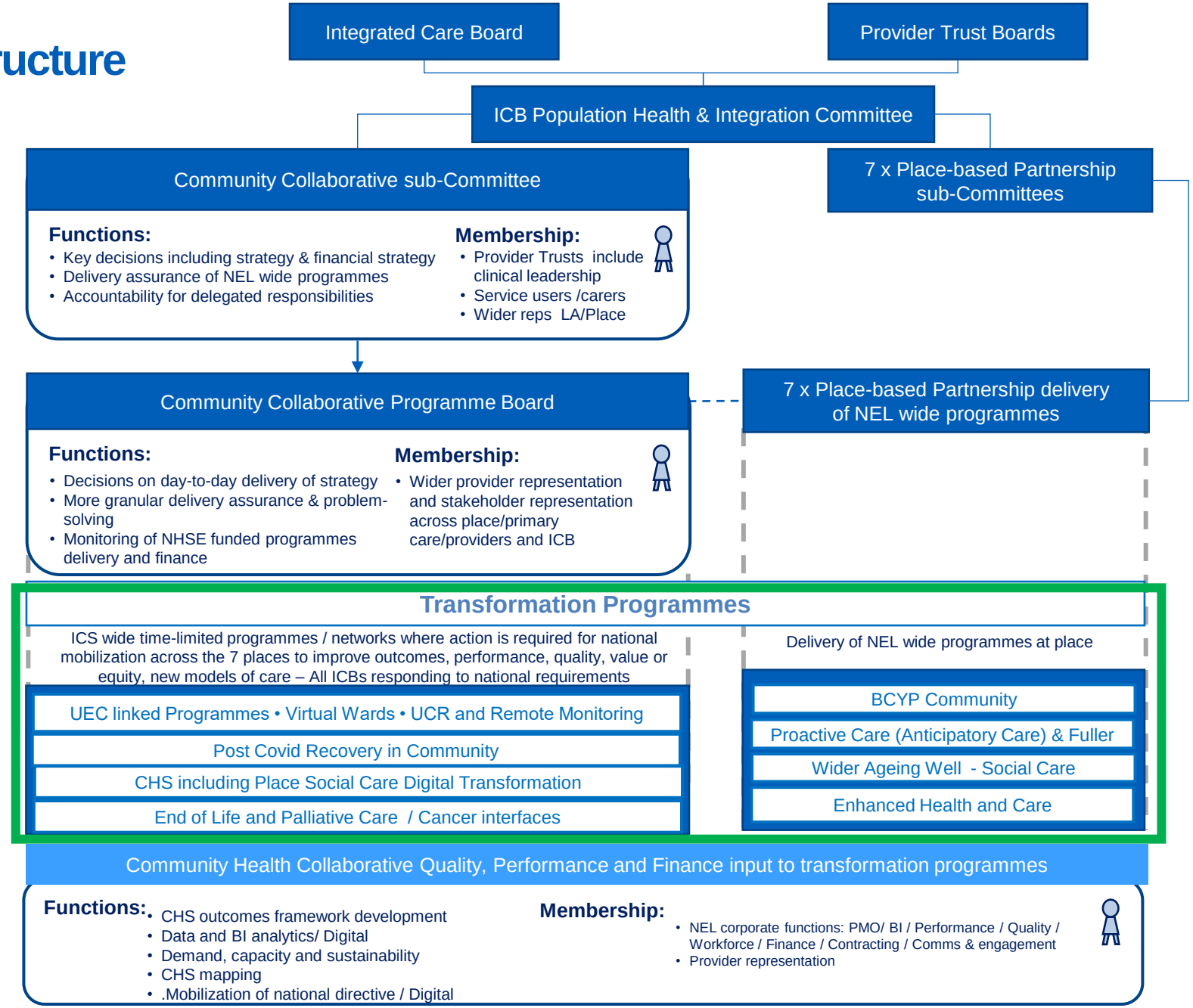
Delivery & Initial governance structure

Common ways of working governing our approach:

- **Commitment to resident engagement and co-production** at all levels
- **Clinical Leadership** - Relevant clinical leadership at all levels
- **Output / delivery & impact focused** Forward plans & PMO approach and clearly agreed strategy or ToR held for all projects /programmes/ task and finish groups
- **Test and Scale** – Joined up working to test and scale
- **Matrix** working core both vertical and horizontal
- **Data** Using Population health management to underpin delivery – currently in development community dashboard for NEL with key data sets

Key things to note

- **Around 20+ million SDF budget** Ageing Well, Long Covid, Virtual Wards, Digital other ad-hoc in-year etc.
- **Community Contracts** – 400+million, 50 providers
- **Interfaces** – Planned Care, Primary Care, VCS, Acute
- **Enablers** – Collaborative Digital Strategy key to development of services in addition to this is data demand and capacity, waiting lists etc.



Ongoing National CHS LTP priority commitments across 2023/24 – Operating Plan Links

Putting people in control of their own care through more personalisation

(Government Mandate to the NHS, 22/23)

Growth and development of integrated neighbourhood teams to support our most vulnerable and complex patients to stay at home and access care in the community

(Fuller Stocktake)

Deliver an additional 2,500 Virtual Ward (VW) beds, effectively utilised both in terms of addressing the right patient cohort and optimising referrals.

(NHS Winter Letter)

Actively consider establishing an Acute Respiratory Infection (ARI) hub to support same day assessment

(NHS Winter Letter)

Putting in place a community-based falls response service in all systems for people i.e. who have fallen at home including care homes

(NHS Winter Letter)

Ensuring that patients receive personalised care tailored to their individual needs

(NHS Standard Contract 22/23)

Comply with the new statutory duty for ICBs to commission palliative and end of life care services in response to population needs, drawing upon NHSE statutory guidance.

(Palliative and end of life care: Statutory guidance for integrated care boards (ICBs))

Shift more care to the community, including safe and convenient care at home or close to home, through developing the capacity and capability of community health services, integrated neighbourhood teams and new models of care

(NHS England operating framework)

Strengthen the hands of the people we serve through the comprehensive model of personalised care including supporting people to have increased choice and control over their care based on what matters to them as well

(NHS England operating framework)

Priority Workplan for Community 23/24

Operating Plan deliverables

- Delivering a reduction in CHS waiting times to pre-covid pandemic levels or better
- Delivery of the Ageing Well Programme working with partner organisations (UCR, Proactive Care/ Anticipatory Care, Wider Ageing Well initiatives Inc. Enhanced Care Homes)
- Delivery of Virtual Wards aspiration and links to wider UEC delivery plans
- Oversight of Covid pathways as these move into BAU where relevant (Pulse Oximetry, Long Covid, remote monitoring)

Service quality and resilience

- Making best use of community bed capacity and improving resilience to winter / Covid pressures
- Work with Workforce Leads from the ICS to address common recruitment and retention issues through innovative employment and training approaches
- Increase resilience in fragile services e.g. dietetics
- Babies, Children and Young People(BCYP) services interfaces including the development of new pathways

Strategy and development

- Develop a vision and strategy for CHS within the ICS and agree a CHS Outcomes Framework
- CHS Deep Dive
- Engage in end-to-end pathway planning through clinical networks and other provider collaboratives

NEL Community Collaborative Further work

Governance

- The Community Collaborative Operating Model is currently being implemented.

Review of key areas of work

- The initial 2023-24, workplan has been developed and continues to evolve to deliver the requirements set out by NHSE (further details included on the following slide and in *Appendix A*).
- However, a number of key areas that continue to be in discussion and remains in progress. These include:
  - Agreeing the scope for the Collaborative (CHS) partners as it matures to deliver transformation across community services and the resources required to allow effective delivery
  - Clarification of the accountability for current community based care programmes
  - Scope of the Collaborative in future strategy and planning rounds
  - Improve transparency of resource availability and allocation across collaboratives / place
  - Further clarification of the roles and responsibilities of the resources at ICB/Collaboratives and Place and the interdependencies between the teams, functions and other Programmes of work across the ICB

NB. There are identified dependencies with place/collaboratives and clinical networks that may affect initial workplan as the system develops

Community Collaborative Current Priority Work Areas

- Continue to strengthen governance process
- Develop co-production with providers and voluntary sector
- Strengthen patient leadership and service user inclusion
- Virtual wards stock take and deep dive
- Digital solutions for virtual ward operations
- Babies, Childrens and Young People, Speech and Language Therapy waiting times review
- Develop scope for community services mapping exercise

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North East London Health & Care Partnership

Health updates

INEL JHOSC July 2023

NHS NEL – The Big Conversation

North East London Health & Care Partnership

The Big Conversation is about listening to the people in our communities, and understanding their views about health, care and wellbeing. It will help us focus on what matters to local people and how we can work with them and use their insight to improve what we do.

Based on what we already know about the needs of local people, the Big Conversation focuses on our four priorities for improving quality and outcomes and tackling health inequalities: **Babies, children and young people**, **long term conditions**, **mental health** and **local employment and workforce.**

We are running an online survey open until 31 July (with over 300 responses as of 22 June) and holding a series of events throughout June and July in local areas and online, with different groups and focusing on different topics, supported by local Healthwatch.

We encourage committee members to come along to the events, complete the survey and encourage friends and colleagues to do the same.

Analysis will take place in August with an event planned for Autumn to look at findings and how we use these to develop success measures to hold ourselves to account on and report on regularly.

For more info: The ‘Big Conversation’ - North East London Health & Care Partnership (northeastlondonhcp.nhs.uk)

NHS NEL Organisational structure

North East London Health & Care Partnership

- NHS NEL (NEL Integrated Care Board) is restructuring in order to meet the challenges and opportunities provided by the Health and Care Act 2022 and other influences such as the NHSE requirement to reduce our budget by 30% by 2025/26 (which means a greater reduction in reality as we need to fund and account for inflationary pressures)
- We want to improve patient and public participation (both in developing health and care solutions, and in taking control of their own health); and to get all parts of the health and care system working collaboratively. We want our staff to have fulfilling and enriching careers in the ICB and to benefit from working with colleagues in the NHS and our partners
- NEL conducted a staff consultation from 18 April to 16 June and we are currently finalising the structure, with staff expected to transition to new roles at the end of October/start of November
- However there will need to be further work on the structure e.g. to accommodate new commissioning responsibilities and staff for pharmaceutical, general ophthalmic, dental, and primary care complaints services (transferring 1 July 2023)
- (See also the paper on Place Partnership Mutual Accountability Framework)

NEL ICS 23-24 operating plan summary

North East London Health & Care Partnership

Funding Stream	Revenue Resource £'000s
Recurrent Funding	3,659,132
Primary Care Funding	392,894
Dental, Ophthalmic and Pharmacy	215,905
Running Costs	38,745
Non Recurrent Funding	99,225
Total ICB Funding	**4,405,901**

- NEL ICS submitted its final 23-24 operating plan in May 2023. The plan shows a system breakeven however some parts of the system are required to generate surpluses to support deficits in others.
- Total ICB funding equates to £4.4bn, and includes specific allocations with regard to Primary care and running costs.

- To achieve breakeven the system will have to deliver £278m of efficiency savings. This presents a significant delivery challenge for all parts of the system. The efficiency savings are made up of a combination of non recurrent in year measures, increases in productivity, additional income and reductions in temporary staffing costs and non pay costs.
- At month 2, the ICS has a year-to-date adverse variance to plan of £25.7m, including an ICB £7m variance. The key drivers for overspends are as follows;
    i. Efficiencies - month 2 reported slippage against planned year-to-date efficiencies of £18.1m.
    ii. Inflation – providers and the ICB have reported additional costs as a result of inflation being higher than planned levels.
    iii. Payroll costs – providers have reported pressures in relation to pay, including agency staffing.
- A number of recovery actions across the system have been put in place, centred upon the delivery of efficiency programmes that will need to recover the year to date slippage seen.
- The level of recurrent pressures within the system underlying position mean that there will need to be a strong focus on efficiency and productivity through 23/24 and 24/25.

Strike action

North East London Health & Care Partnership

- The strike action by nurses at the Royal College of Nursing will not continue after fewer than 50% of the membership voted. Unison and other colleges except Unite and the Royal College of Radiographers have accepted the deal. However we should be under no illusions about the dissatisfaction amongst the workforce about the settlement.
- The three junior doctors' strikes have had an inevitable impact in all sorts of ways; from the time spent to plan, manage and cover for strikes; the backlog of operations that has built, and the financial cost . Acute trusts have prioritised patient safety, with consultants providing cover and minimised the effect as best as possible, but nevertheless there has been significant impact.
- Those people who had operations cancelled were prioritised for re-booking. However aims to reduce the number of people on long waiting lists will be imperilled by future strikes.
- A fourth strike by junior doctors is planned for this month as well as one by consultants which would result in one in three working days in July being a strike day. It is evident that a significant number of doctors, at all stages of their careers, are unhappy with NHS pay and conditions. The risk in the medium to long term is that they will be less likely to commit to a future in the health service.
- BHRUT along has spent close to £1m on staffing to fill rotas and lost a similar amount of income from work that couldn't take place during the industrial action.

Barts Health

North East London Health & Care Partnership

Strike action and urgent and emergency care:

- We have now had three separate phases of **junior doctors industrial action** in March, May and June. During the strikes we have prioritised patient safety, with consultants providing cover in medical wards and in ED. In May we cancelled 7,600 routine outpatient appointments and 422 elective procedures to enable this.
- **This has impacted our long waiter position**. Those who were cancelled were prioritised for re-booked by our hospital teams.
- Our hospitals remain extremely busy. For April 2023, Barts Health recorded the highest volume of A&E attendances of any trust in England. Our **performance against the 4-hour standard improved in April** with all hospitals over 70%, putting us 8th out of 16 London Trusts.
- **Mental Health** patients presenting in ED continues to present major challenges. Although attendance numbers are stable, the time they spend in ED has increased significantly. We continue to work with system colleagues to find sustainable solutions to this challenge

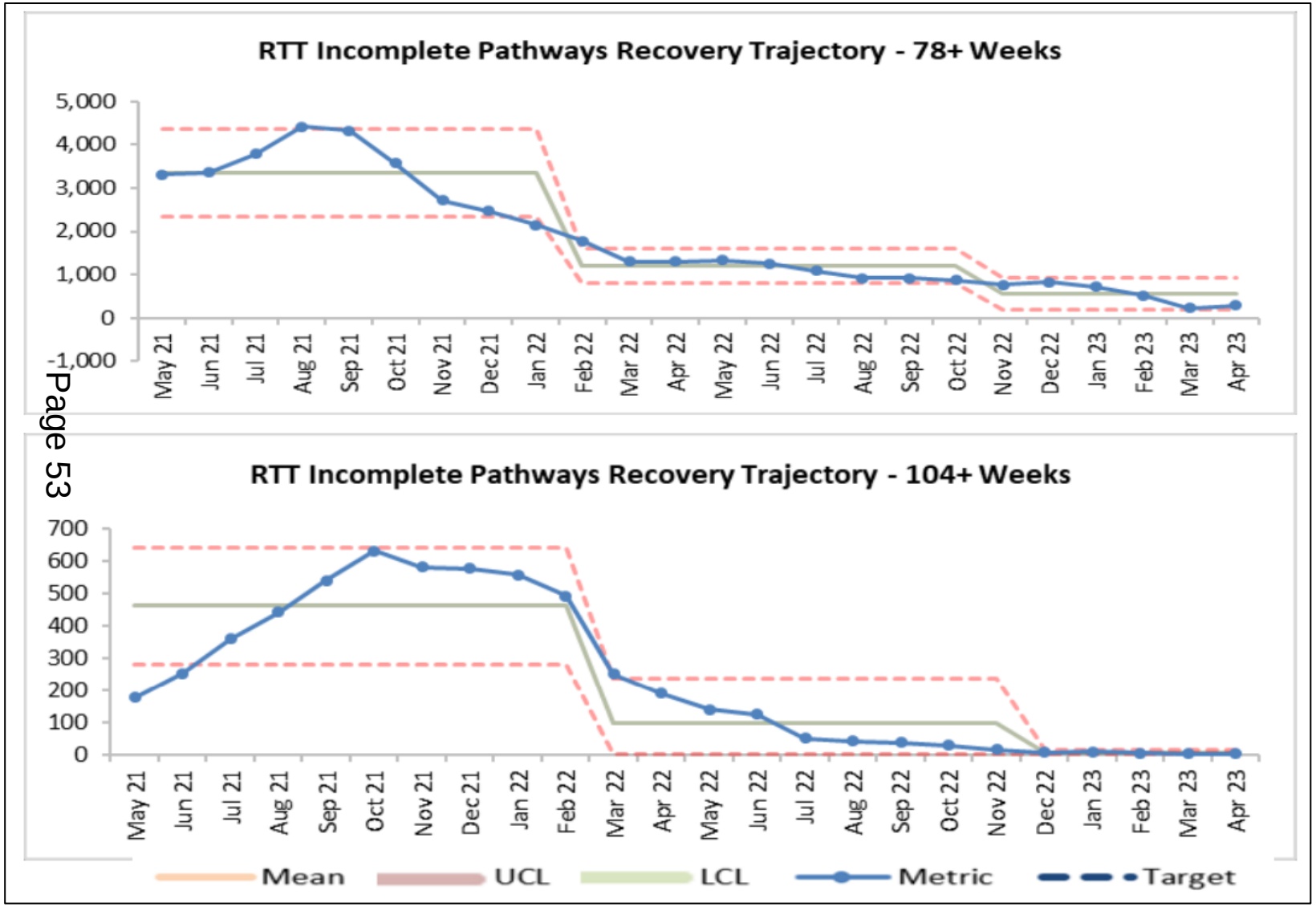
Planned care recovery:

- Our activity volumes for April and May have been strong when allowing for the strike action, at 95% of our annual plan. Hospitals are developing their local productivity plans to ensure we are treating as many patients as possible. We're making progress on long waiters (see slide 2)
- We have now launched patient portal, **Patient Knows Best** which allows patients to access their health record online. Initially this will let them see appointment info and will reduce the number of people not attending appointments. Over time they will also be access other information including scan and test results. *Please encourage your local communities to sign up to this at* https://www.bartshealth.nhs.uk/patients-know-best

Strategic updates:

- The Secretary of State has announced that the **Whipps Cross development** is among the list of projects that will proceed. We'll continue to work with national colleagues in the new hospital programme to agree next steps for completing the business case.
- Our new ***We are Barts Health*** document charts our strategic direction as we refresh our clinical strategy in partnership with the other acute trusts and NHS bodies in north east London.
- The insourcing of over **1,794 people from Serco** has now completed – which took place over the past 7 months and included porters, security and reception teams. We are confident that this will improve the service patients receive, and we've already seen improvements in cleaning.
- Amanjit Jhund has been appointed as **Chief Executive Officer for Whipps Cross Hospital** and will assume responsibility from 17 July

Planned care recovery



78 Week waiters

- Our 78 week waiters peaked at over 4,000 during the pandemic
- This is reduced significantly; at the end of April, 294 patients were waiting 78+ weeks for a treatment or procedure which has reduced to 198 in June.
- Our target is to see all patients who have been waiting 78+ weeks by the end of June, however this has been impacted to some extent by junior doctor industrial action, which had cancelled some of these appointments

104 week waiters

- We have now all but cleared our two year waiters, however there continue to be very small numbers who breach this date – as at June there is just one person waiting
- This is due to patient choice or where the surgery required if very complex

Homerton Healthcare

North East London Health & Care Partnership

Operational performance

- **Daycase and elective activity** achieving 103.92 % against plan YTD (Apr'22 – Mar'23) with May'23 achieving 99.68 % against plan.
- **Outpatient first appointment activity** achieving 103.73 % against plan YTD (Apr'22 – Mar'23) with May'23 achieving 104.38 % against plan.
- **Elective care performance** Trust's May PTL position is 28,154 . The number of pathways transferred from other NEL trusts – c. 6,959 pathways to-date. 107 patients waiting over 52 week at end of May'23.
- **Cancer** – currently below 62-day treatment target (63.1% in Apr'23); achieving 2ww referral target (94.85% for May'23)
- **4-hour emergency care target** in May'23 is 77.43 % compared to 83.5 % in Apr'23.
- **Community services:** IAPT position for May'23 is 96.6% seen within 18 weeks with strong performance of 57.9% against the recovery rate (Target 50%).

Corporate activity

- In April, Bas Sadiq became the new Deputy Chief Executive followed in May by Dr. Emma Rowland taking up the post of Chief Operating Officer. The HHFT executive team is now fully staffed with substantive post-holders.
- The Trust launched our new 5-year strategy in May with six key priorities that will help us continue our work towards providing everyone in City and Hackney access to outstanding healthcare.

BHRUT

North East London Health & Care Partnership

Urgent and emergency care (UEC)

- Following the expansion of Same Day Emergency Care (SDEC) at Queen's Hospital, we have now opened SDEC at KGH, to help reduce unnecessary admissions.
- We have also opened a new discharge facility at Queen's Hospital to improve patient experience while waiting to go home, and help improve flow from A&E to the ward.
- Trust type 1 performance in May was 40.48%, a significant improvement on the previous 20 months.
- Patients with mental health conditions continue to wait for long periods of time - in May, the average wait for to be moved to a service better able to care for their needs was almost 20 hours.

Finance

- At the end of May, our deficit was £5.8m adverse to plan, due, in part, to industrial action, inflationary costs and slippage against our waste reduction programme.
- We continue to focus on establishing and maintaining the right size of the organisation; making pay rates more equitable and affordable; and getting better value for money from suppliers.
- In May, we stopped paying for high-cost agency nurses – also known as off framework – in line with our May deadline.

Senior leadership

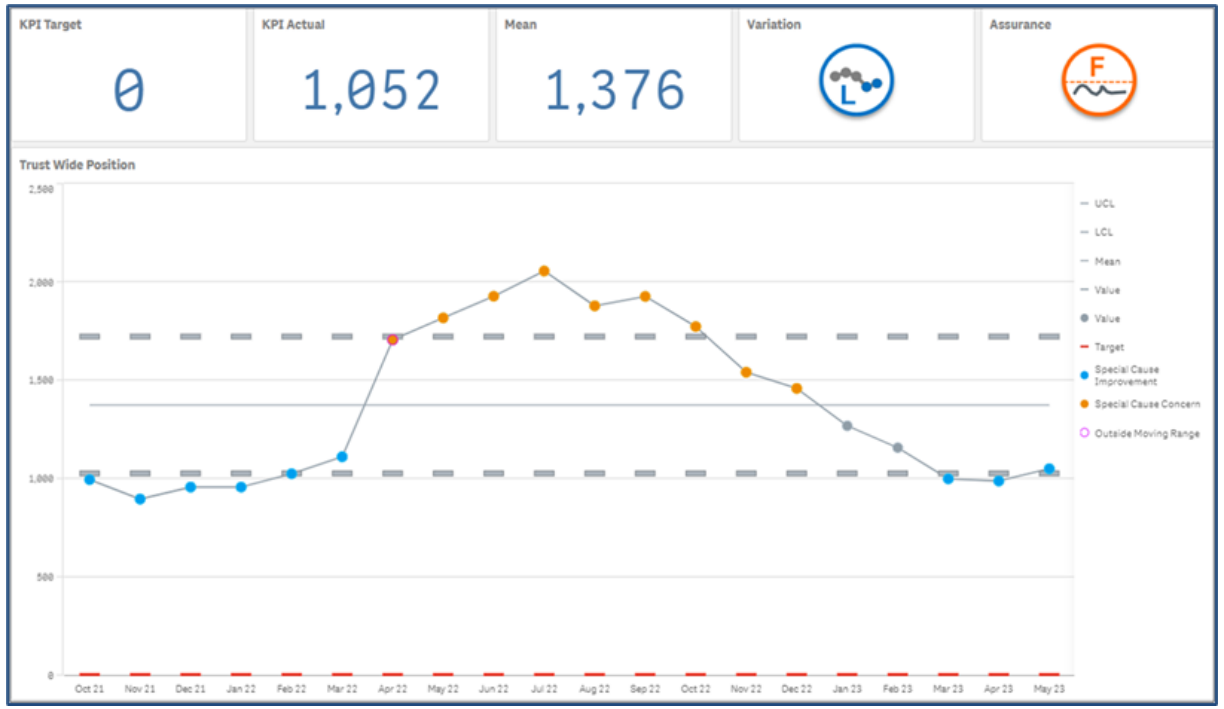
- Fiona Wheeler has been appointed Chief Operating Officer. Under her leadership of our planned care recovery programme for the past year, we have seen a significant reduction in waiting lists. All our senior leaders are now substantive appointments and the stability this brings will greatly benefit our patients and staff.

Reducing our waiting lists

North East London Health & Care Partnership

- One way we're further reducing waiting time for treatment is by increasing use of our theatres to 90 per cent of available sessions, up from 84 per cent in early 2022. This is despite having to reduce our planned surgery by 15 per cent (equivalent to the loss of one theatre) due to a national increase in demand on emergency surgery.
- We remain ambitious in our plans to eliminate waits of more than a year by Christmas, although this may be impacted by having to rearrange almost 6,200 outpatient appointments and 450 surgeries as a result of industrial action to date by junior doctors.

Patients waiting over 52 weeks



- Work on our £14m Elective Surgical Hub expansion at King George Hospital is taking shape. We welcomed Julian Kelly, Chief Financial Officer at NHS England at our topping out ceremony to celebrate the new building reaching its highest point. And NHS Providers published a case study on the work we've been doing around our Community Diagnostics Centre (CDC) at Barking Community Hospital, where additional diagnostics capacity is proving invaluable in helping address our backlog. The CDC is due to open in December. Professor Sir Mike Richards, who recommended CDCs following his review of NHS diagnostics capacity, recently visited the site.

ELFT and NELFT

North East London Health & Care Partnership

NELFT and ELFT

North East London Health & Care Partnership

Service demand

- Demand pressures have continued to be significant across North East London, across all ages, and both for crisis and routine referrals. The trusts are working together and with partners to support our service users.

Metropolitan Police announcement: Mental health callouts

- It was announced in late May by the Metropolitan Police Commissioner, Sir Mark Rowley, that the police intend to make changes to their response to mental health related calls, in line with the Right Person, Right Place scheme that has been running in Humberside over the last few years. We are working closely with police colleagues in North East London to consider the implications of any changes for services locally, and to make necessary changes to arrangements.

NEL Mental Health UEC Improvement

- Across North East London, we are introducing a range of services that aim to improve the capacity of the Mental Health Urgent and Emergency Care pathway. These include:
  - Additional acute bed capacity on the Goodmayes site
  - Additional Health Based Place of Safety capacity
  - Additional staff in Emergency Departments and additional assessment space created.
  - Joint Mental Health Response Cars with the London Ambulance service

NELFT and ELFT

North East London Health & Care Partnership

Community Health services development

- A number of priority service developments are being taken forwards, including the development of Virtual Wards in the community, work on Speech and Language Therapy, and delivery of the Ageing Well programme.

NHS 75

- A free events took place in East London to celebrate 75 years of the NHS. The London Community Fayre was held on **Wednesday, 12th July from 14:00-16:30 at Toynbee Hall, 28 Commercial Street, London, E1 6LS**.
- NHS75 Food Festival Goodmayes, held on **Wednesday 5 July, 12:00-16:00 at Goodmayes Hospital, 157 Barley Lane, Ilford IG3 8XJ**
- NELFT launched the NHS75 Community Cookbook on 5 July– a free cookbook full of recipes from staff, patients and carers. Donations are welcome with proceeds going to The Health Way Foundation.

Patient and Carer Race Equality Framework (PCREF)

- Both Trusts have been trailblazers for the PCREF work nationally, working with patients, carers and communities to improve experiences and outcomes.
- NELFT's PCREF launch event is **09:30-16:00 14 July London Chigwell Prince Regent Hotel - Princess Suite Manor Road Chigwell IG8 8AE**

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North East London Health & Care Partnership

NHS North East London

Joint forward plan update INEL JOSC

Johanna Moss – Chief Strategy and Transformation Officer

Introduction to Joint Forward Plan (JFP)

- 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).**
- As well as setting out how the ICB intends to meet the health needs of the population within its area, 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.
- As such, the **JFP provides a bridge between the ambitions described in the integrated care strategy developed by the ICP and the detailed operational and financial requirements contained in NHS planning submissions**.
- ICBs and their partner trusts should review their JFP before the start of each financial year, by updating or confirming that it is being maintained for the next financial year. They may also revise the JFP in-year if they consider this necessary.
- The purpose of the JFP is to describe how the ICB, its partner NHS trusts and foundation trusts intend to meet the **physical and mental health needs of their population** through arranging and/or providing NHS services addressing the **four core purposes of the ICS, the universal NHS commitments and meeting the legal requirements of the guidance.**

Relationships between strategy and plans

Transformation or addressing inequalities and service redesign

Integrated Care Strategy – this sets ICP strategic priorities to meet the needs of our population

Describes the needs of our population and the strategic challenge including health inequalities	Discusses how we will address the needs of our population and address health inequalities through the 4 ICS priorities	Describe how we will work differently as a system to deliver against the 4 ICS priorities	Describe the impacts of the 4 ICS priorities on our population and workforce

Joint Forward Plan – Sets out how the integrated care strategy priorities and the NHS operational planning requirements will be met

How it will deliver on Integrated Care Strategy priorities, key NHS priorities and NHS universal commitment (performance standards)	What part of the system will be delivering the Integrated Care Strategy priorities, key NHS priorities and NHS universal commitment (performance standards)	How it will exercise its core functions to deliver the Integrated Care Strategy priorities, key NHS priorities and NHS universal commitment (performance standards)	How it will organise and develop the system to deliver the Integrated Care Strategy priorities, key NHS priorities and NHS universal commitment (performance standards)

Impact

Activity and performance trajectories

Operational Planning Guidance – Sets out what we aim to deliver in 23/24

Activity trajectory for planned and unplanned care	Cancer and elective performance trajectories	Mental Health trajectories	Out of hospital, primary care or place based trajectories

Development of the Joint Forward Plan (JFP)

- As a delivery plan for the north east London (NEL) Integrated Care Strategy, we have worked with our partners, including the seven Places to develop the JFP. Importantly, this is where our people live and where they are part of their local community with its local priorities and services.
- This plan outlines how we are working together as part of a wider system where we are addressing health and care needs and improving services everywhere across north east London.
- A first draft was completed by the end of March, and since then, we have engaged with our Health and Wellbeing Boards, our Place-based Partnerships and our Provider Collaboratives as well as wider partners to ensure alignment to partner plans and to identify any gaps.
- Based on the feedback we have updated the JFP and it will be published on the web at the end of June. A short summary is included below, and the full document is available as an appendix.

Key changes incorporated in the final version

- We have updated certain sections where the content has moved on, such as finance and workforce to ensure alignment with new and emerging strategies.
- We have enhanced certain sections, such as inequalities and inclusion, to ensure full representation of the range of work underway in these key ICS priorities.
- We have reviewed some of the terminology to ensure consistency.
- We have also received feedback related to how we work as a system. As a response we have added a slide called ‘We will continue to evolve as a system’. Further work will be taken forward with our partners around system development, design of a new system planning cycle and how we will strengthen the way we measure the impact of our programmes.
- We have added a slide on how we have engaged and aligned with health and wellbeing board priorities.

Strategic alignment with local health and wellbeing priorities across NEL

Hackney

- Improving mental health
- Increasing social connection
- Supporting greater financial security

City of London

- Good mental health for all
- A healthy urban environment
- Effective health and social care integration

Waltham Forest

- The best start in life to develop, thrive and achieve
- Healthy, longer, happy lives prosperous, active and sustainable
- Thriving maturity and protected community: safe, supported and independent

Redbridge

- Achieving the best start in life
- Diabetes prevention and management
- Mental wellbeing
- Cancer survival
- Living well in a decent home you can afford
- End of life care

Havering

- Assisting people with health problems (back) into work
- Further developing the Council / NHS Trusts as 'anchor institutions'
- Provide strategic leadership for collective efforts to prevent homelessness and the harm caused
- Realising the benefits of regeneration for health and social care services
- Improve support to residents whose life experiences drive frequent calls on health and social care services
- Obesity
- Reducing tobacco harm
- Early years providers, schools / colleges as health improvement settings
- Development of integrated health and social care services for CYP and adult s at locality level

Tower Hamlets

- We can all access safe, social spaces near our homes, so that we can live active, healthy lives as a community
- Children and families are healthy, happy, and confident
- Young adults have the opportunities, connections and local support they need to live mentally and physically healthy lives
- Middle-aged and older people are enabled to live healthy lives and get support early if they need it – whether it is for their mental or physical health
- Anyone needing help knows where to get it, and is supported to find the right help

Newham

- Enabling the best start through pregnancy and early years
- Supporting our young people to be healthy and ready for adult life
- Supporting people around the determinants of their health
- Developing high quality inclusive services, ensuring equity and reducing variation
- Meeting the needs of those most vulnerable to the worst health outcomes
- Creating a healthier food environment
- Supporting active travel and improved air quality
- Creating an active borough
- Supporting a Newham of communities where people are better connected and supported
- Working towards a smoke free Newham
- Building a borough of health promoting housing
- Building an inclusive economy and tackling poverty

Barking and Dagenham

- Best Start in Life
- Early Diagnosis and Intervention
- Building individual and community strength

*Note these are joint health and wellbeing priorities which may evolve as place based partnerships become more established

Next steps

Next steps

Building on our learning from the process this year, we are now looking to co-design a system planning cycle with our partners over the summer that will bring together and streamline different planning processes to optimise the way we plan.

While we will continue to respond to any further central guidance issued, our approach will be primarily geared towards bringing local partners together with local people to tackle knotty issues and develop innovative solutions for the short, medium and longer term.

We have outlined the proposed high-level steps below:

July:

- System wide workshop to co-design the system planning cycle

September and October:

- Workshops with partners and local people to test our strategic context and the outcomes we want to achieve based on outputs from the Big Conversations

October to December:

- Theme-based workshops to test the current transformation programmes, their alignment with the strategy and the operational priorities feeding into a refresh of the Joint Forward Plan for 24/25

January to March:

- Work with partners to develop our operational plan as a system

Areas for further development

- The JFP outlines the key programmes at place and system level where we have visibility of them but we recognise that there is more to do to identify the full breadth of transformation activity across all partners / parts of the system and to develop this into a system plan aligned to our strategy.
- We have also heard from our social care and care provider partners that there is more we need to do to integrate plans and work programmes across our whole system building on some of the foundations that are in development such as the work on local authority data sharing.
- As we design our processes for next year, kicking off after the summer, we will be working with Place-based Partnerships to ensure that care partner plans and priorities are fully reflected in local priorities as well as utilising opportunities for regular engagement and involvement with groups at the system level such as the DASS and DCS groups and Care Provider Voice forum.
- We will also explore how we can present the JFP differently in future to make it easier for our places to navigate from a local perspective.

North East London Health & Care Partnership

NHS North East London

Summary – North East London (NEL) Joint Forward Plan

Introduction

This Joint Forward Plan describes how the local NHS and our partners (Local Councils, charities, voluntary groups and others) plan to improve the health and care of local people for the next five years.

We can’t simply keep doing what we do now. More and more people are moving into our area and we already have some of the worst pockets of poor health, and the longest waits to see GPs or get treatment in hospitals and A&E in London.

Our residents also have some of the highest rates in the country for child and adult obesity, diabetes and heart disease. Many are living in poor or insecure housing and in low income families which lead to poorer health.

That’s why local doctors, hospitals, Councils, voluntary groups and community services such as mental health, must work better, and smarter, to use the limited money and staff available to us to improve things for everyone. This document tells you how we plan to do that and includes links to more detailed information on our plans if you want to read it. We’re also being honest about the things that need to happen for our plan to work.

Challenges and Opportunities

We need a completely new approach to how we work together to deliver health and social care for local people across north east London. We also need to spend more time and resources on prevention – helping people to take better care of themselves before they get sick and then need to rely on the NHS and others. If we don't do this, we'll never be able to afford to properly care for you and your families in the future. Things have to improve.

Improving how we work

We've improved the way we work together to plan and deliver health and social care so we can get more for our money, and so we can focus on prevention and on earlier diagnosis and better care in the right place. This means a new approach to everything from emergency care in hospitals to looking after people with ongoing health issues, from GPs and mental health to those needing tests and more routine operations.

Different parts of our local health and care 'system' have been working hard to tackle most of these things for years, but we've never all come together before to agree the best way forward and to come up with a plan like this. So, what are we doing?

Our priorities (1/5)

Long term conditions

We’re putting in place seven day a week services for everyone with symptoms of a mini stroke, focussing on prevention and better care for those with Type 2 diabetes and improving our heart failure care services right across the area. We’ll also help more kidney patients to have dialysis at home where appropriate.

This part of our plan relies on us having enough staff for the new clinical teams, getting the funding we need and getting everyone working in health and care locally to sign up to our plan.

Mental health

Our plans will see shorter waits in A&E for people with mental health needs, more support workers, better access to Talking Therapies for anyone that needs it, more personalised care and a focus on mental health service users helping us to develop and improve those services. We’ll also be offering mental health support in every secondary school across our area.

We need to tackle high rates of staff vacancies in some areas and make sure that we bring together everyone that works in mental health to be as coordinated as possible to plan and deliver the very best care for children and people who need help.

Our priorities (2/5)

Maternity

We’re working to ensure all women are offered dedicated care throughout their pregnancy, that we greatly reduce some of the things that can go wrong – especially for women in deprived areas, and that GPs and other baby services work more closely with our maternity staff. We also want more women to breastfeed their babies.

This part of our plan relies on us recruiting/training more maternity staff and being able to fund more research into the future demands on our maternity services so we have the right service in place for women now and in the years to come.

Babies, children and young people

We’re making sure that children aged 5-11 who are overweight, get the help they need to be healthy. We’re planning more help for families with very small children nearer to where they live, supporting children with special needs to be ready to for starting school and more support for families who are struggling to know where to go for help when they need it.

Our plans rely on families with obese children recognising that they need help, on recruiting more staff and on more funding to care better for those children with special needs.

Our priorities (3/5)

Employment and workforce

We're employing another 900 staff in the next year for the health and care services described above and we want everyone to be paid fairly. Our plans will see more GPs and clinical staff in practices and less reliance in our hospitals on expensive temporary staff, with more full-time nurses and doctors. We also want to employ more local people to train and work here in the NHS.

Our plans rely on more funding to bring in the extra staff we need and also on keeping the staff we have – many are suffering from 'burn out' as a result of the pandemic and the constant pressure they are under.

Community health services

We're working with local Healthwatch and the voluntary sector to help people coming out of hospital to be able to stay safely at home, we're focussing care on those with several health conditions, employing 2,000 more staff to help the terminally ill and their families and ensuring that all our services can see one single care record for a patient.

This part of our plan relies on us getting the funding, solving some of the privacy issues around sharing records and attracting those new staff and/or training local people.

GPs and pharmacists

We're making use of latest technology so people can more easily get help from their GP, including remote appointments, helping some GP practices to improve levels of care and their quality ratings, introducing more pharmacy services and improving all our 'same day' services.

This part of our plan relies on us being able to fund some of the technological changes we want to make and on everyone involved participating in our plan and making the necessary changes.

Our priorities (4/5)

Urgent and emergency care

We're making it easier for you to book urgent appointments, finding ways to educate and support people who use the service when they don't really need to, working with the ambulance service to only bring people who need hospital care to A&E, and finding new, streamlined ways to care for people who need same day, urgent care.

This part of our plan relies on us getting the funding we need, getting to grip with the different ways this care is delivered across our area now and continuing to make it as easy as possible for residents to know how and where to get the care they need.

Cancer

We're working to be able to detect cancers earlier, giving people a better chance of a full recovery. At the moment we're focussing on earlier diagnosis of lung, prostate, pancreatic and liver cancers and working towards personalised care and support for all our patients. We also want to increase the numbers of people coming forward for screening so we can catch cancers earlier.

This part of our plan relies on solving some of the staffing issues at local hospitals which mean we can't do as many, or turn around tests as quickly as we'd like to.

Our priorities (5/5)

Operations and tests

We're reducing waiting times for people currently on lists for an operation and opening new centres across the area for people to get faster ultrasound and CT scans and tests for cancer and other conditions. We're also increasing the number of operations taking place in our hospitals' theatres and working hard to bring all our services up to the same high standard for all our residents.

This part of our plan relies on us being able to recruit more staff, expand some operating theatres and improve our technology to help quicker decision making.

Health inequalities

We know that health care, and people's experience of it, isn't the same in different parts of north east London. This is particularly the case for people living in our more deprived areas, those from ethnic minorities, for carers, those with learning disabilities, autism and for the homeless. We plan to improve this so that everyone, no matter who they are or where they live, gets the best care possible and lives a healthier life.

Once again, we need the funding and the staff with the right skills and expertise to put our plans in place.

North east London – improving all the time

The way the NHS works with local councils and the voluntary sector has changed a lot in recent years. Most of the health and care issues that local people have, however, remain the same.

This latest plan looks to get the very best value for every pound we spend and to use and support our brilliant staff – now and in the future - in the best, most productive way possible. We are looking at how we can work together to streamline care and stop duplication, which is frustrating for patients and our staff. The plan will be updated as the years go by because we need to plan, but also adapt to new challenges such as lots more people coming to live here.

We want to involve local people as much as possible in everything we do. That's why we'll be coming to you to ask for your help and ideas as we work together to improve the health and lives of everyone across our area.

For more information about who we are and how we are working with our partners to improve health and care for people across north east London, click here.

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North East London Health & Care Partnership

NHS North East London

FINAL DRAFT

North East London (NEL) Joint Forward Plan

June 2023

1. Introduction

Introduction

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

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

In submitting our Joint Forward Plan, we are asking for greater recognition of three key strategic challenges that are beyond our direct control. The impact of these challenges is 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

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**

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

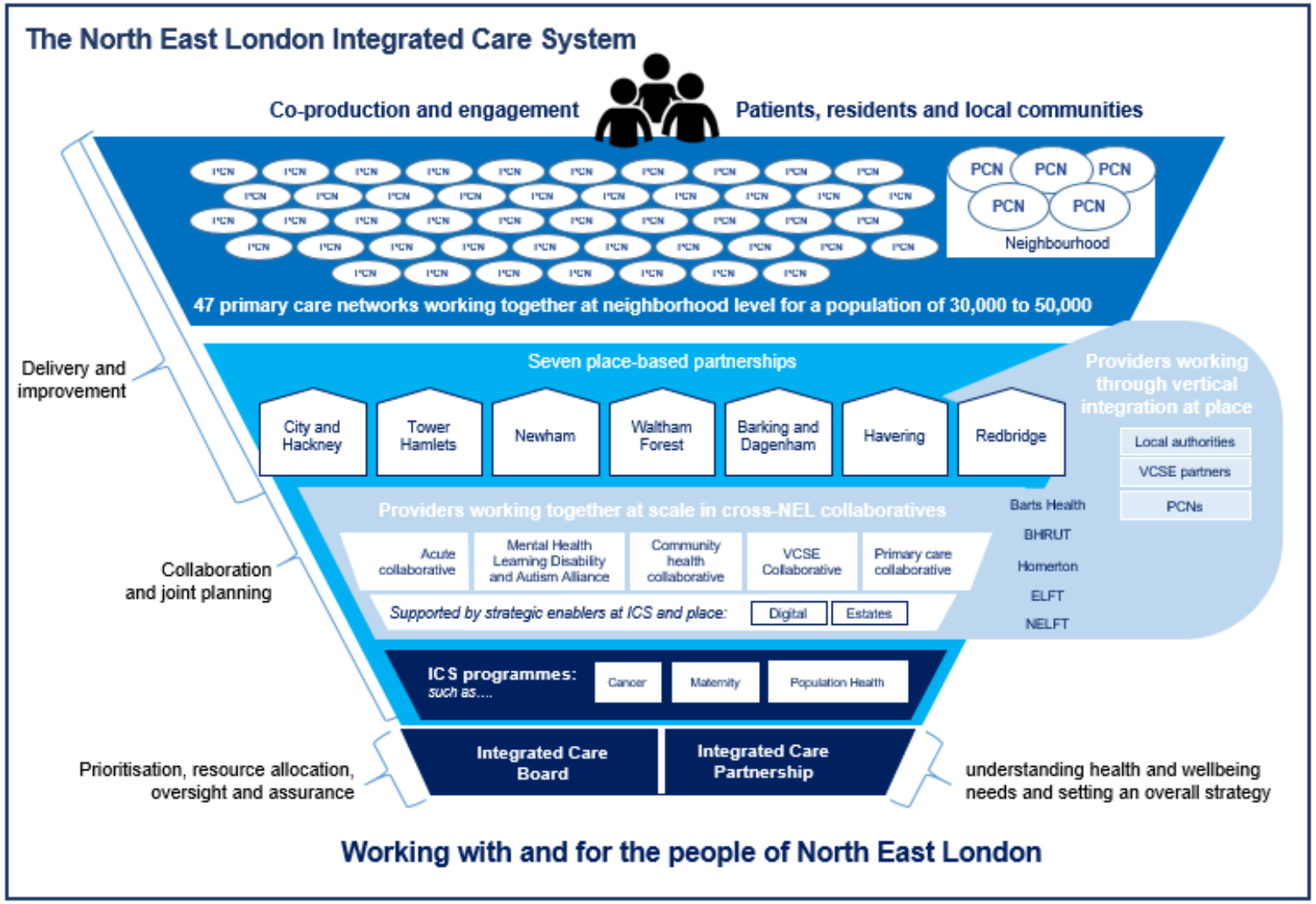
We are a broad partnership, brought together by a single purpose: to improve health and wellbeing outcomes for the people of north east London.

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

Our partnership between local people and communities, the NHS, local authorities and the voluntary 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.



2. Our unique population

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

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

Rich diversity

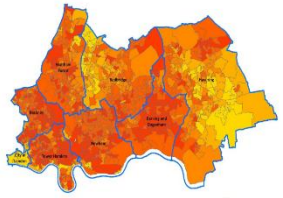
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from ethnic minority backgrounds.

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

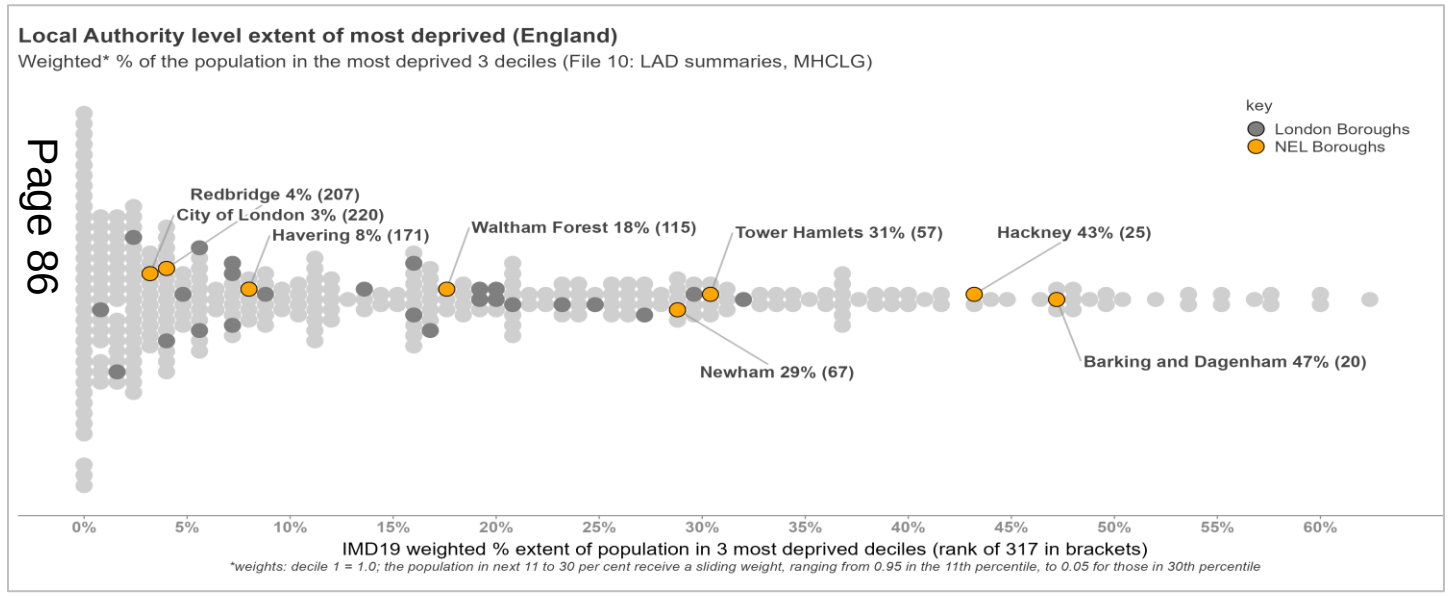
There are significant inequalities within and between our communities in NEL. Our population has worse health outcomes than the rest of the country across many key indicators. Health inequalities are linked to wider social and economic inequalities, including poverty and ethnicity.

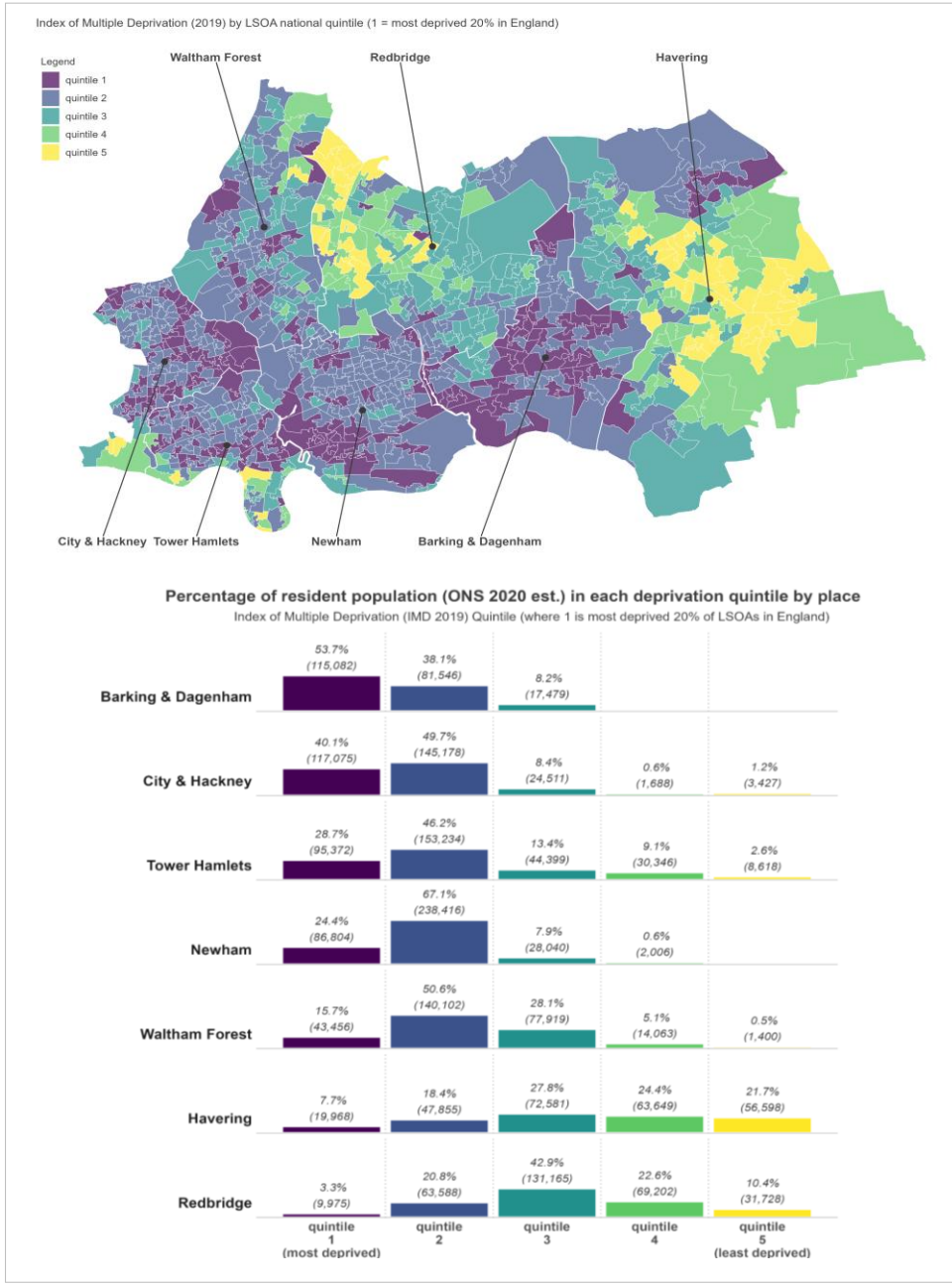
Our population has been disproportionately impacted by the pandemic and recent cost of living increase.

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.

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.

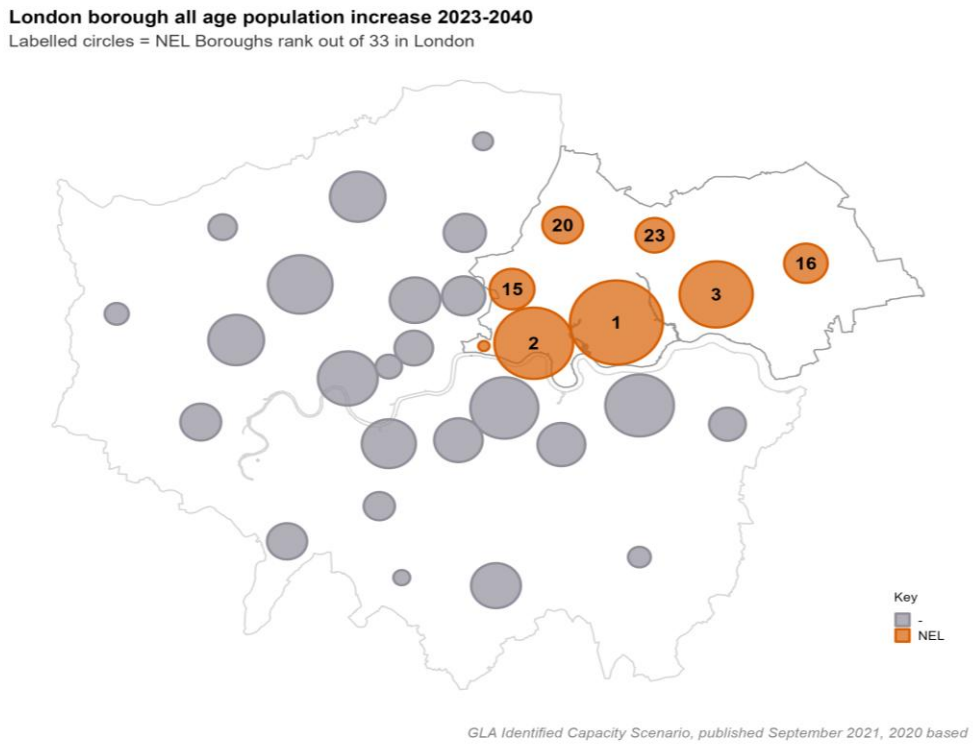
Our population is not static – we expect it to grow by over 300,000 in the coming years, significantly increasing demand for local health and care services

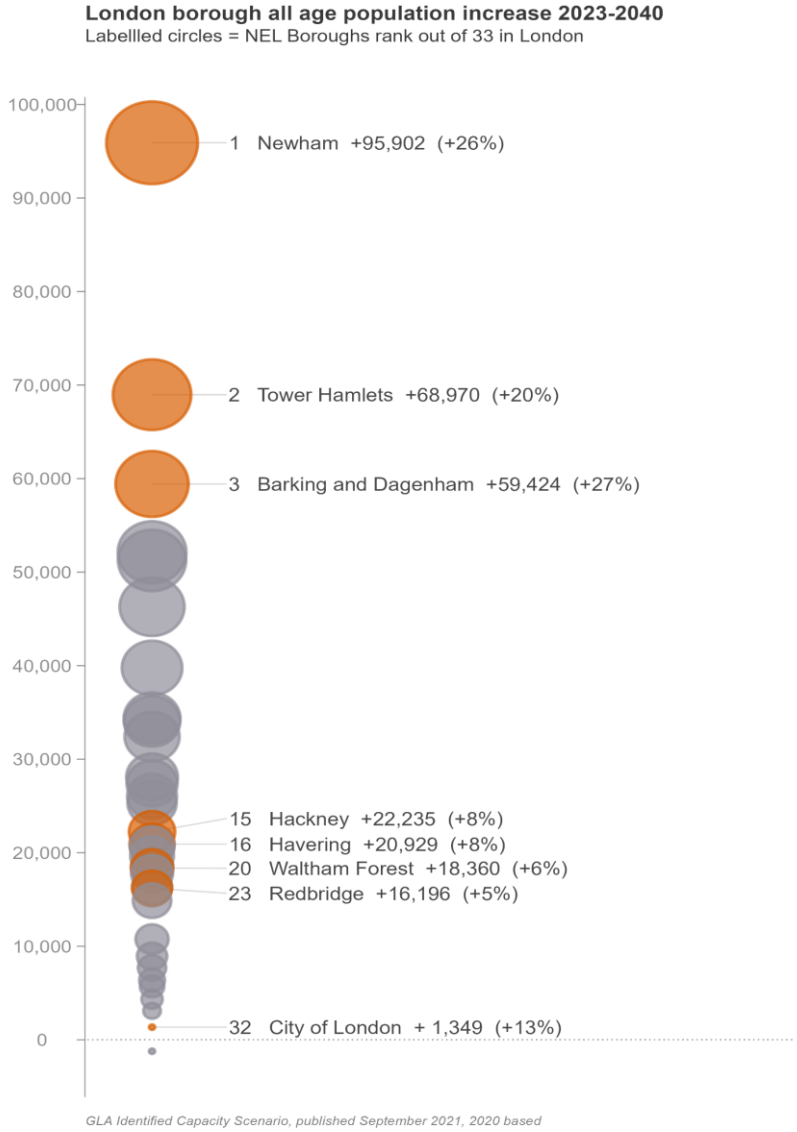
The population of north east London (currently just over 2 million) is projected to increase by almost 15% (or 300k people) between 2023 and 2040. This is equivalent to adding a whole new borough to the ICS, and is by far the largest population increase in London.

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.





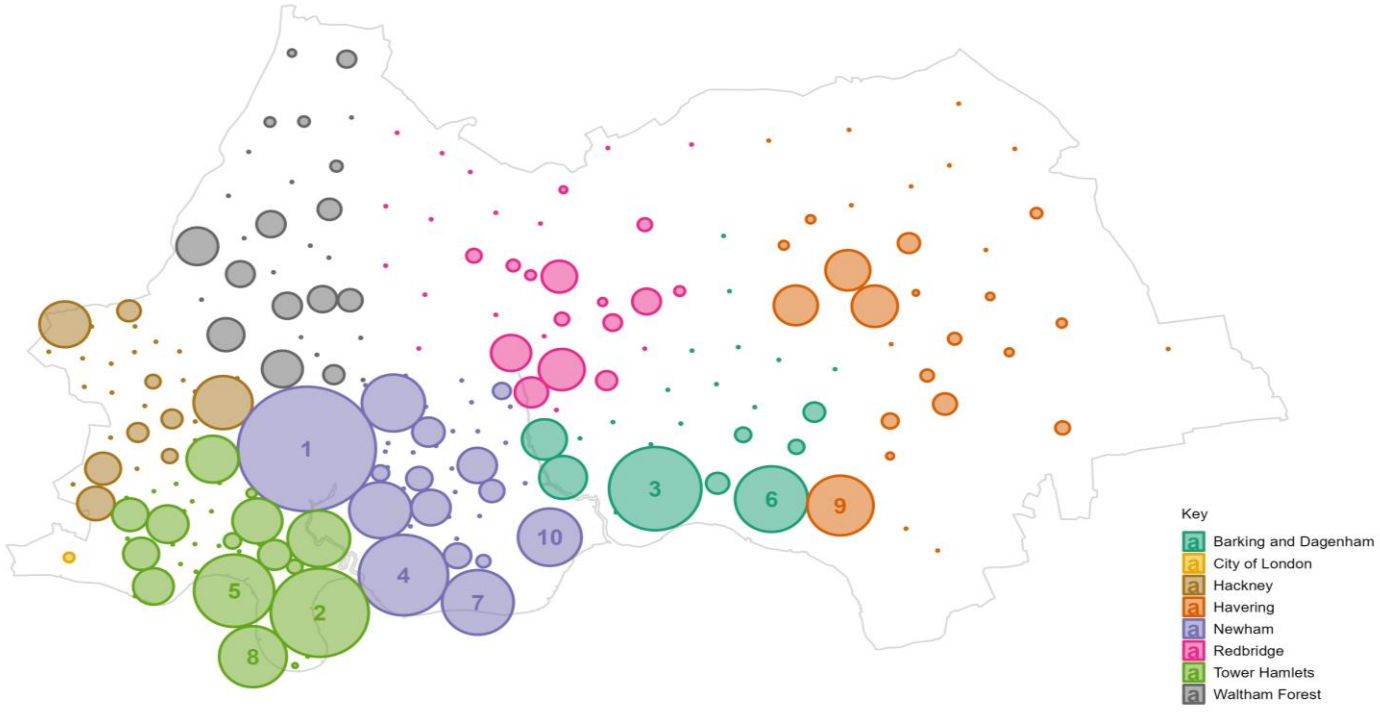
We need to act urgently to improve population health and address the impact of population growth

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

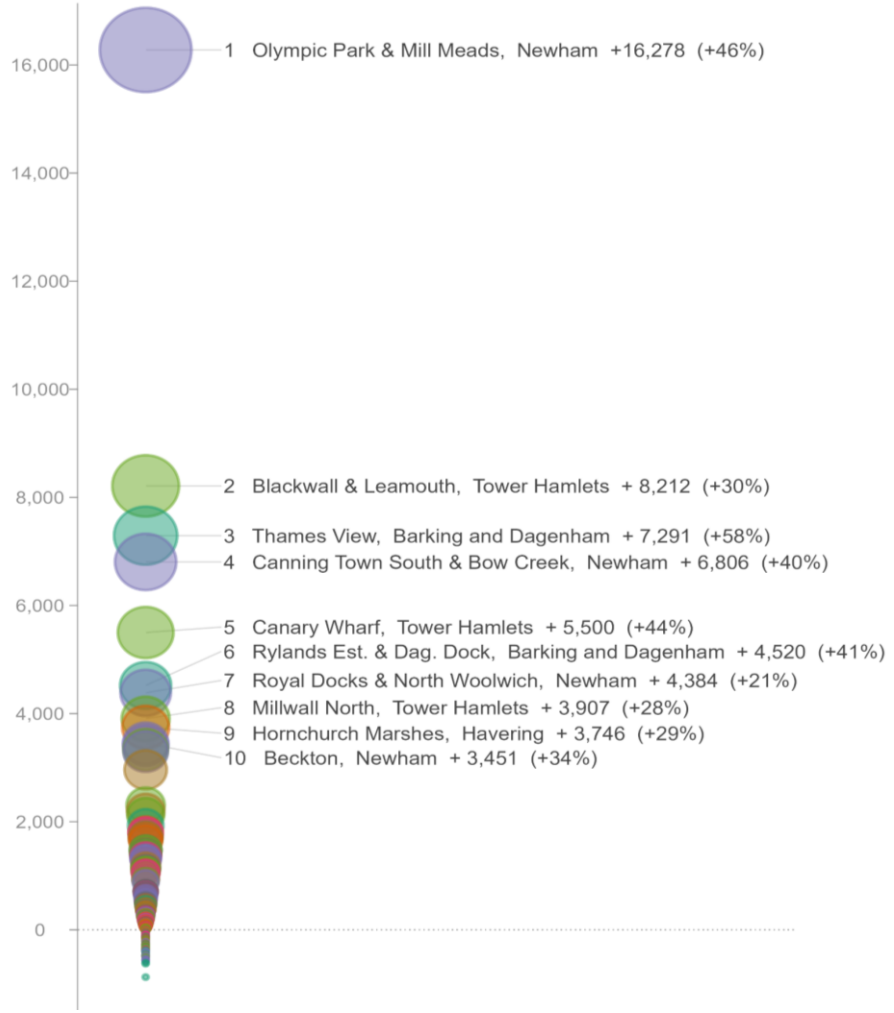
Smallest circles = MSOAs with zero increase or marginal decrease, labelled circles = top 10 NEL neighbourhoods by population increase (1=highest)



GLA Identified Capacity Scenario, published September 2021, 2020 based

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

Labelled circles = top 10 NEL neighbourhoods by population increase



3. Our assets

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.

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.

Our ICS People and Workforce 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' across the system that will work in new ways and be seamlessly deployed for the delivery of health and care priorities. The strategy will focus on increasing support for our current 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 4,000 people working in general practice with 3.7% growth in our workforce in the last year
- 46,000 people working in social care
- 49,000 people working in our Trusts

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

Voluntary, Community, and Social Enterprise (VCSE) organisations are essential to the planning of care and 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.

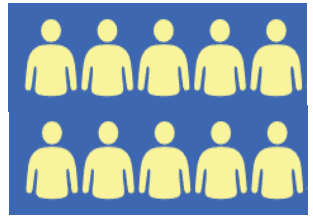
In NEL we are supporting the development of a VCSE Collaborative to create the enabling infrastructure and support sustainability of our rich and diverse VCSE in NEL, also ensuring that the contribution of the VCSE is valued equally.

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.

4. Our challenges and opportunities

The key challenges facing our health and care services

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

Two of the most pressing and visible challenges our system faces today, 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.

We face substantial pressures on same day urgent care

Key messages	*Detail*
Demand for same day urgent care is growing rapidly as NEL's population grows	• Demographic and non-demographic changes to the NEL population are projected to increase demand for A&E attendance and unplanned admissions by 15-16% over the next 5 years
The status quo isn't viable. Doing more of the same will exacerbate existing pressures	• We have significant performance challenges across all three acute Trusts (e.g. average 60% on 4 hour A&E target) • Growing demand for unplanned care within acute settings risks undermining efforts to reduce backlog of patients waiting for planned care
Improvements in care pathways, including a shift of system resource to out of hospital services (primary and community care), could help reduce demand for expensive unplanned acute care for some patients	• Rates of avoidable admissions (for conditions that ought to be manageable through better primary care) are high at a large number of primary care practices within NEL (between 37 and 46 depending on the type of avoidable admission) • Mental Health patients are facing long waits in A&E (4,440 waited more than 12 hours during 22/23) • Non-conveyance from ambulance calls to care homes vary considerably and represent a higher proportion than the London average • Around 13% of A&E attendances leave without any significant investigation or treatment, suggesting they could have been better managed elsewhere in the system
Patients on waiting lists are causing pressures across other parts of the system	• A snapshot of the current elective waiting list indicates that 14% of the patients waiting for elective care have been responsible for 47,000 A&E attendances during their wait
There is an opportunity for improving UEC by better system working	• An analysis of NEL against other London ICSs indicates that moving to the median ICS performance for non-elective admissions would see a reduction of around 10%. This would be a substantial contribution to closing the projected gap created by growing demand and equates to around £65m per year

We have a large backlog of people waiting for planned care

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

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

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

- North-east London currently has 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.
- Across NEL there is wide variation in the number of delivered appointments or average clinical care encounters per week. 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.**
- Between March 2022 and March 2023, booked general practice appointments across NEL increased by around 32% to 11 million appointments. 56% of appointments were delivered by other professionals such as nurses and 43% 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.***
- We are developing a set of principles 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 committed to focusing upon retention initiatives 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.
- Community care in north east London is currently fragmented, with around 65 providers offering an array of community services. More work is required to understand the impact this has on patient outcomes and variability across NEL's places, but we know that for pulmonary rehab, for example, there is variation in service inclusion criteria and the staffing models used, and that waiting times vary between 35 and 172 days, with completion rates between 36% and 72% across our places and services.
- More children and young people are on community waiting lists in NEL than any other ICS (NEL is about average, across England, for the number of people on adult community waiting lists).
- There are opportunities to build on our best practice to further develop integrated neighbourhood teams, based on MDTs, social prescribing and use of community pharmacy consultation services, which will strengthen both our continuity of care of long term conditions and our ability to work preventatively.

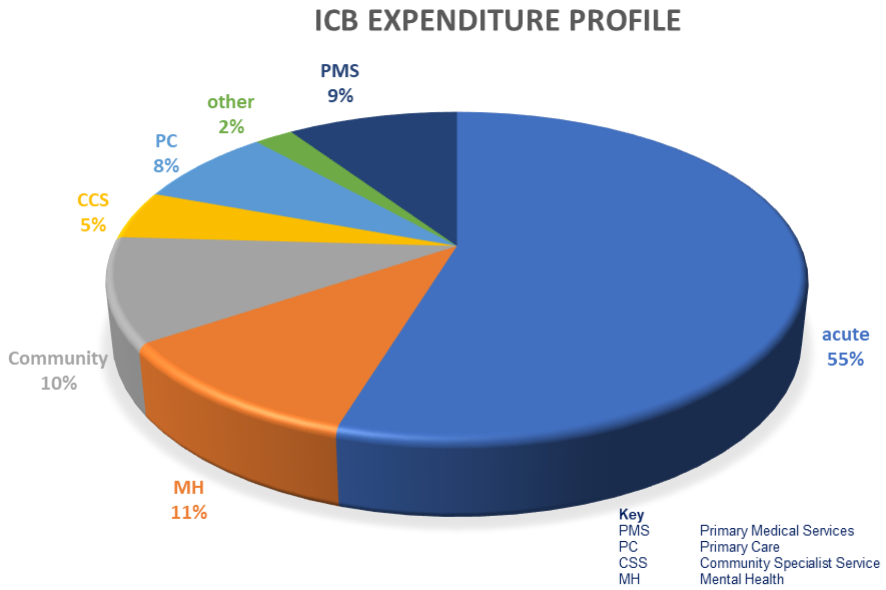
Long term conditions

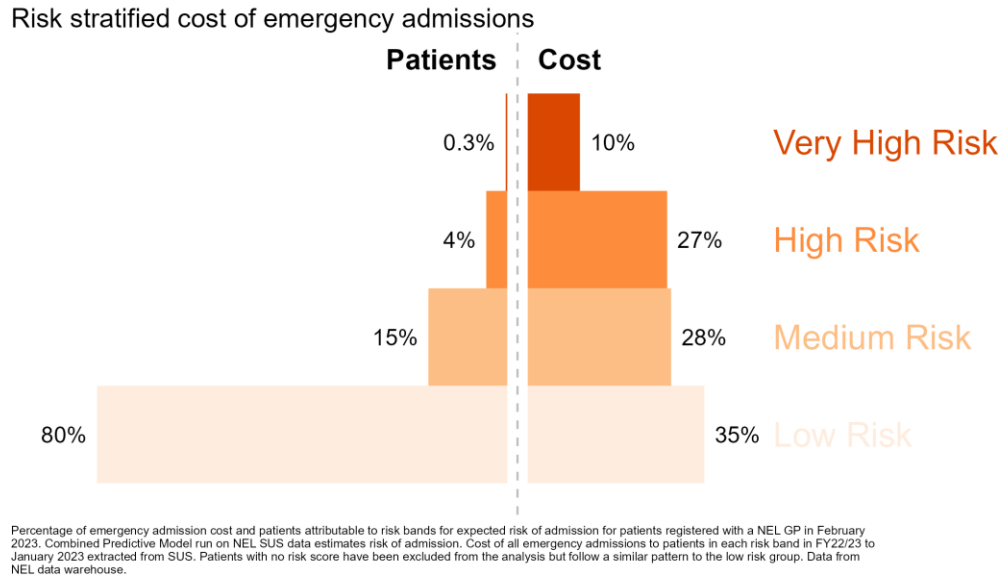
- Across north east London, one in four (over 600 thousand people) have at least one long term condition, with significant variation between our places (in Havering the figure is 33%, vs 23% in Newham and Tower Hamlets).
- Age and deprivation are strong predictors of long term conditions, so while north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

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

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.
- Current plans to improve the financial position, such as productivity/cost improvement programmes within the Trusts, are expected to close some of this financial gap and we know there are opportunities for reducing unnecessary costs, such as agency spend. In NEL, agency spend is 7% of total spend vs 4% median for London ICSs.
- In addition to a financial gap for the system overall, there are 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 (around £90m), significantly less than other London ICSs (which receive between £130m-£233m) and comparable to systems with populations half the size of NEL*. This puts significant pressure on the system and its ability to transform services, as well as maintain quality estate.
- There is huge variation in the public health grant received by each of NEL's local authorities from central government. 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

5. How we are transforming the way we work

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

- The previous section set out the challenges that the north east London health and care system needs to address to succeed in its mission to create meaningful improvements in health and wellbeing for all local people
- 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 cross-cutting programmes

4. Our supporting infrastructure

5. Local priorities within NEL

Urgent and emergency care

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

Over the next two years

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

Over years three to five

- Further development of virtual consultations for U&EC

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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

Community health services

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

- April 2024:
  - greater digital interoperability and one shared record to include universal care plans, which enables more joined up care across providers
  - standardisation of access to palliative care services across north east London
  - access to post-covid rehabilitation within four to ten weeks of persistent ongoing symptoms and access to specialist services within four weeks of GP referral
  - proactive care assessments for local people with two or more long-term health conditions
  - at least 551 virtual ward beds with an integrated acute and community provision model
- April 2026:
  - a shared care record for health and special care, leading to better feedback loops for local people
  - 2,000 generalist staff trained on a range of palliate care delivery areas
  - standardisation of quality of, and access to, palliative care services across north east London
  - post-covid care is part of a business as usual offer within community provision
  - an equitable offer of proactive care across north east London

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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

Primary care

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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

Planned care and diagnostics

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

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

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

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

Key programme features and milestones:

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

Key milestones include:

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Cancer

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

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

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

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

Key programme features and milestones:

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

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

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:

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

Maternity

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

- April 2024:
  - All women experiencing urinary incontinence to be able to access postnatal physiotherapy up to 1 year post delivery
  - Reduced unwanted variation in the delivery of care (through the regional service specification)
  - Increased breastfeeding rates, especially amongst babies born to women from black and minority ethnic groups or those living in the most deprived areas
- April 2026:
  - The majority of women are offered Midwifery Continuity Care, prioritising the provision to women from Black and minority ethnic (BAME) groups who will benefit from enhanced models of care.
  - A single digital system across NEL for maternity care records
  - Improved post-natal care to support areas such as reduction in smoking, obesity, and other public health concerns
  - Better integrated maternity and neonatal services and improved interface with primary care

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

- 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 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

Key programme features and milestones:

- Delivering key maternity safety actions
- Achieving the Ockenden Essential Actions in collaboration with the Neonatal Operational Delivery Network
- Supporting the recommendations of the Neonatal Critical Care Review
- Facilitating and supporting leadership cultural development
- Supporting the recruitment, retention and well-being of maternity workforce
- Supporting the training and education of maternity staff, in partnership with Health Education England
- Implementing the NEL equity and equality action strategy and action plan
- Implementation of the Senior Maternity and neonatal advocate role across NEL

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

Alignment to the integrated care strategy:										
	Babies, children, and young people	X	Mental health	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

Babies, children, and young people

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

Over the next two years to five years

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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

Long term conditions

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

April 2024:

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

April 2026:

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

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

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

Key programme features and milestones:

- Roll out of the LTC outcomes framework (Q2 23/24) (led contractually by primary care)
- Co-produce 7 day TIA service with local people so that 90% of people with TIA will have access 7 days a week to a stroke professionals who can provide specialist assessment and treatment within 24 hours of symptom onset thus preventing long term disability
- New Digital PR DHI with shared-working between places (co-production start March 2023 with potential capacity for c.250 extra participants a year).
- Acute Respiratory Infection (ARI) Virtual Wards (with plan for provision in each Place before Winter 23/24).

Further transformation to be planned in this area:

Over the next two years

- Improve acute stroke standards and flow across the stroke pathway

Over years three to five

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

- Failure to formalise joint working agreements between partners, teams and functions affecting delivery of NEL wide plans to address regional, national and local ambitions.
- Financial reduction in NHS SDF funding in 23/24 affecting sustainability of programmes across LTCs
- Workforce availability to staff new clinical teams and staff programme team

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

Mental health

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

April 2024:

- A common personalised care planning tool focused on what matters most to service users (DIALOG) will be in place across all of north east London by the end of 2023/24
- Personal development and support will be available through our Lived Experience Leadership Programme for children, young people and adults with lived experience of mental health, which will enable service users and carers to co-produce/co-deliver improvements across the system, and work towards paid employment, if that is their aim
- Additional adult mental health hospital beds to ensure people do not experience long waits in emergency departments, coupled with improved crisis support services in the community

April 2026:

- Increased numbers of peer support workers across all-age mental health services, with a coordinated approach to training, recruitment, support and retention across the system
- Improved equity of access, outcomes and experience of NHS Talking Therapies for minoritised communities and other under-served populations (e.g. people with long term health conditions and older adults)
- Equity of access to physical health checks for people with severe and enduring mental illness, in particular for people from minoritised communities and people living in the most deprived communities
- Working towards an equitable offer of support to children and young people in 100% of secondary schools

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

- The partners of the Mental Health, Learning Disability and Autism Collaborative have commissioned a system diagnostic to help us understand the outcomes, experience, equity and value that patients receive for the money we spend on mental health services across the system. The outputs of this work will help to shine a light on the inequities between boroughs, but also between communities and groups with protected characteristics. It will pave the way for a more equitable approach to resource allocation in the future
- Using Quality Improvement tools and techniques we are developing a number of improvement networks to lead the programmes of work that are best delivered at scale, led by clinicians and service users. Improvement networks focus on sharing learning, reducing unwarranted variation, and tackling health inequalities within and between borough populations
- For example, through our Crisis Improvement Network and service user 'Think Tank' we are committed to developing and testing plans to address the over-representation of black men being detained in hospital for treatment
- The Mental Health, Learning Disability and Autism Collaborative is committed to developing and implementing anti-racist commissioning practices which aim to build trust between the NHS and VCSE organisations, deliver more equitable and sustainable funding to the sector and improve the health and wellbeing of minoritised communities

Key programme features and milestones:

- By the end of summer 2023 we will have recruited to our dedicated People Participation Lead and People Participation Worker to develop our Lived Experience Leadership Programme for adults with mental health needs
- By September 2023 we expect to have finalised the outputs of the system diagnostic
- By November 2023 we will have opened additional acute bed capacity at Goodmayes Hospital
- By January 2024 we will have completed our business case for Lived Experience Leadership resource for children and young people

Further transformation to be planned in this area:

Over the next two years:

- We will roll-out NHS 111 press 2 for mental health and improve our existing mental health crisis lines and crisis alternatives
- We will expand NHS Talking Therapies to include 16 and 17 year olds

Over years three to five:

- We expect our Lived Experience Leadership Programme to enable service users and carers to initiate transformation and improvement projects themselves, supported by our programme team and the networks

Programme funding:

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

Leadership and governance arrangements:

- Mental Health Learning Disability Autism Collaborative Committee (we are expecting this to become a joint committee of the ICB, ELFT and NELFT Boards from July 2023 onwards)
- Programme boards
- Improvement networks
- NEL ICS Place-based partnership boards and local governance arrangements

Key delivery risks currently being mitigated:

- In some boroughs, reduced access to some mental health services (e.g. NHS Talking Therapies, Children's Eating Disorder Services) has been caused by high numbers of staff vacancies. These will be mitigated through focused efforts to improve recruitment and retention in our Improvement Networks
- Some programme areas / improvement networks sit across multiple portfolios (e.g. paediatrics, long term conditions, primary care, frailty, end of life, planned care, social care, acute) which means there can be a lack of clarity across places and the system on leadership and improvement goals. This risk could be mitigated through the support of the NEL Senior Improvement Advisers to coordinate across collaboratives and pathways of care

Alignment to the integrated care strategy:

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

Employment and workforce

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

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

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

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

Key programme features and milestones:

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

Further transformation to be planned in this area:

- Over the next two years
  - Develop five-year co-designed NEL ICS workforce strategy action plan to deliver objectives, priorities and programmes
  - Build and grow out of hospital workforce with focus on development on GP and Primary Care workforce to deliver services at Neighbourhoods
  - Shared workforce across health, technology, starting with acute collaboratives, Care using collaboratives
  - Increase substantive posts within providers to reduce reliance on bank and agency and productivity
  - To explore feasibility of training academies to support pipeline

Programme funding:

- Currently non recurrent, Funding from NHSE and GLA against long NEL priorities
- Funding redistribution to NEL strategic priorities as we move to new models of community care

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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

Health inequalities

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

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

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

Reducing health inequalities is a cross-cutting theme embedded within all of our transformation programmes within places and across NEL. Improving health equity and population health is a core focus for our place-based partnerships and neighbourhoods. For example, dedicated health inequalities funding has been provided to each place to lead locally determined programmes to reduce health inequalities within their local communities. Taking a population health management (PHM) approach, led by places and neighbourhoods, will support frontline teams to identify high risk groups and address unmet health need. A PHM Roadmap has been developed for NEL.

To support opportunities across NEL, some specific targeted inequalities programmes have been developed including for Refugees and Asylum Seekers, Homelessness, Tobacco dependence treatment services, Developing a NEL anchor system and Net Zero and implementing the Green Plan (see related JFP reference pack for details). We have also established enabler programmes to support system-wide work on health equity:

- Establishing a NEL Health Equity Academy will support people and organisations working in health and care in north east London to be equipped with the knowledge, confidence and skills to reduce health inequalities.
- Agreeing a shared ambition to reduce health inequalities, and funding local action towards achieving this ambition over three years.

All programmes and services will support the Core20Plus5 and the ICP Strategy:

- Applying a poverty lens to all our work. This includes paying particular attention to the health and social needs of people living in poverty, reviewing their access to, and usage of, services, tackling unmet need, and addressing the wider determinants of health through making every contact count and through our role as anchors.
- Ensure we are measuring and addressing ethnic disparities, including in our waiting lists, a strong focus also on cultural competency, building trust and tackling racism.
- Support for carers running through all our priorities and wider transformation programmes.
- Ensure all services are accessible, appropriate and effective for people with learning disabilities and autism, increase the number and quality of annual health checks and vaccinations for Covid-19 and flu, reviewing deaths to ensure we have up to date data and action plans to address health inequalities and safeguarding.
- Collaborate to improve the quality of health and care services for people experiencing homelessness and reduce the mortality gap between people who are homeless and the rest of the population.
- We are committed to being an intentionally anti-racist system where we prioritise anti-racism, understand lived experience of staff and local people, grow inclusive leaders, act to tackle inequalities and review progress regularly.
- Build our understanding and recognition of intersectionality.
- Review the impact of local place based partnerships in reducing health inequalities and accelerate and invest in scaling up good practice.

Key programme features and milestones:

- Launch NEL Health Equity Academy, September 2023
- Establish the Shared System Ambition, Summer 2023
- Evaluations of place health inequalities projects (22/23 funding), September 2023
- Mobilisation of 3 year place health inequalities plans, Summer 2023

Further transformation to be planned in this area:

- Development of an anti-racism plan.
- Development of a health inequalities outcomes framework.
- Revise and update the NEL population health profile.
- Development of a QI approach for health equity.

Programme funding:

- £6.6m per year for health inequalities funds at place, health equity academy and shared ambition.
- ~£1m per year for tobacco (in baselines from 24/25).

Leadership and governance arrangements:

- Place Based Partnerships
- NEL Population Health & Integration Committee
- NEL Population Health & Health Inequalities Steering Group

Key delivery risks currently being mitigated:

- Financial risk –lack of recurrent investment combined with high inflation affecting sustainability of current provision in some areas e.g. tobacco
- Workforce – capacity, skills and expertise to do everything we can across the system to improve health equity

Alignment to the integrated care strategy:

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

Fuller

The benefits that North East London local people will experience by April 2024 and April 2026:

April 2024:
- Improve same day access through better sign posting and cloud telephony, which enables local people to access different types of health and care professionals in their neighbourhood without having to access specialist services
- Developing a community of practice for Places with regards to enabling local people to access different types of health and care professionals in their neighbourhood without having to access specialist services
- Continue to increase the utilisation of Additional Roles Reimbursement Scheme roles
- Review the requirements at Place and NEL

April 2026
- Local people to be able to access integrated same day services with clear access points and integrated routes between primary and secondary care provision
- Increased population health-based personalisation of people's care at neighbourhood level through wrapping integrated neighbourhood teams around our local people and enabling neighbourhood teams to deliver the majority of care to the population,
- Improve the patient experience through a stable workforce with good retention and staff attendance through a systematic focus on all elements of the NHS People Promise
- Provide seamless care to local people by giving staff access to all the information they need in one pl**ac**e and enable them to share this information safely
- Put in place the appropriate infrastructure and support for all neighbourhood teams
- Reduced health inequalities

How this transformation programme reduces inequalities between north east London's local people and communities:
- This programme works to
  - Shift the culture change needed within our different providers (PC/acute/community/MH) to work as Integrated Neighbourhood Teams around the patient to deliver personalised care
  - Support PCNs and Places to develop and drive the Integrated Neighbourhood Teams implementation and Increased co-location of services and community teams, bringing holistic care closer to home
  - A streamlined integrated approach to managing same day care to ensure local people receive the same level of care regardless of where they live in north east London

Key programme features and milestones:

Same day Access
- Develop better signposting for health care professionals (Q4)
- Pilot, within multiple PCNs, the use of cloud based telephony (Q4)
- Review the interoperability of appointments between primary and urgent care (Q3)
- Develop a contracting framework of in-hours and out-of-hours services (Q3)

Continuity of care
- Establishing a Community of Practice forum (Q2)
- Arrange NEL wide workshop to review current practice (Q1)

People
- Embed the Fuller appraoch of Integrated Neighbourhood teams (Q4)
- Support PCN development and establish a community of practice for ARRS roles (Q3)

Infrastructure
- Deliver Digital First programme (Q4)
- Work with the Local Infrastructure Forum to define estate needs (Q4)

Further transformation to be planned in this area:
- Baselining of the work currently progressing at Place regarding Continuity of Care
- Deliver a NEL workshop bringing together Places to review and share learning of local programmes of work
- Further work regarding recruitment and retention of staff across NEL, particularly focusing on the Additional Roles Reimbursement Scheme
- Establishment of working and task and finish groups to support delivery

Programme funding:
- Currently no programme funding aligned to this programme
- Funding for the programme is proposed to come from existing transformation funding

Leadership and governance arrangements:
- SROs have been confirmed for the four Fuller workstreams, Chief strategy and transformation officer, Medical Director, Chief place and participation officer and MD of Primary Care
- A Fuller Steering Group established with an Oversight Board also proposed
- Currently working to set up workstream Working groups and subsequent task and finish groups will report into the Steering Group

Key delivery risks currently being mitigated:
- Lack of programme funding may limit scope of deliverables
- Lack of programme management to coordinate and drive delivery
- Lack of engagement

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

Physical infrastructure

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

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

Digital infrastructure

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

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

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

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

Key programme features and milestones:

- Single provider for acute EPRs (replacing BHRUT's)
- Single provider for General Practice patient record systems
- East London Patient Record (eLPR) Shared care record across all providers – to be expanded to include social care, pharmacists, care homes, community providers and independent providers
- Promotion of the NHS App as the 'front door' to NHS services, including Patients Know Best (PKB), primary care record, Online Consultations and ordering of repeat prescriptions
- Maternity service digitisation Expanding the Electronic Prescription Service to outpatient services
- Significant investment in facilitators has been made by Digital First to support practice staff to utilise new digital products
- Specific programmes such as PKB include investment in change management and clinical leadership to embed new ways of working

Further transformation to be planned in this area:

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

Programme funding:

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

Leadership and governance arrangements:

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

Key delivery risks currently being mitigated:

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

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

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
- 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

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

Further programmes

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

Further local priorities	
Led by	**Programme**
Acute provider collaborative	Critical care
	Research and clinical trials
	Specialist services (also see p53 to 58)
Mental health, learning disabilities, and autism collaborative	Lived experience leadership programme
	Learning disabilities and autism improvement programme
Barking and Dagenham place partnership	Ageing well
	Healthier weight
	Stop smoking
	Estates
City and Hackney place partnership	Supporting with the cost of living
	Population health
	Neighbourhoods programme
Havering place partnership	Infrastructure and enablers
	Building community resilience
	St George's health and wellbeing hub
	Living well
	Ageing well
Newham	Neighbourhood model
	Population growth
	Learning disabilities and autism

Further local priorities	
Led by	**Programme**
Newham	Ageing well
	Primary care
	Newham Proactive Care Model
Redbridge place partnership	Health inequalities
	Accelerator priorities
	Development of the Ilford Exchange
Tower Hamlets place partnership	Living well
	Promoting independence
Waltham Forest place partnership	Centre of excellence
	Care closer to home
	Home first
	Learning disabilities and autism
	Wellbeing
NHS North East London	Tobacco dependence programme
	NEL homelessness programme
	Anchors programme
	Net zero (ICS Green Plan)
	Refugees and asylum seekers
	Discharge pathways programme
	Pharmacy and Medicine Optimisation/ NEL
	Fuller implementation

Strategic alignment with local health and wellbeing priorities

Hackney

- Improving mental health
- Increasing social connection
- Supporting greater financial security

Waltham Forest

- The best start in life to develop, thrive and achieve
- Healthy, longer, happy lives prosperous, active and sustainable
- Thriving maturity and protected community: safe, supported and independent

Redbridge

- Achieving the best start in life
- Diabetes prevention and management
- Mental wellbeing
- Cancer survival
- Living well in a decent home you can afford
- End of life care

Havering

- Assisting people with health problems (back) into work
- Further developing the Council / NHS Trusts as 'anchor institutions'
- Provide strategic leadership for collective efforts to prevent homelessness and the harm caused
- Realising the benefits of regeneration for health and social care services
- Improve support to residents whose life experiences drive frequent calls on health and social care services
- Obesity
- Reducing tobacco harm
- Early years providers, schools / colleges as health improvement settings
- Development of integrated health and social care services for CYP and adult s at locality level

City of London

- Good mental health for all
- Healthy urban environment
- Effective health and social care integration

Tower Hamlets

- We can all access safe, social spaces near our homes, so that we can live active, healthy lives as a community
- Children and families are healthy, happy, and confident
- Young adults have the opportunities, connections and local support they need to live mentally and physically healthy lives
- Middle-aged and older people are enabled to live healthy lives and get support early if they need it – whether it is for their mental or physical health
- Anyone needing help knows where to get it, and is supported to find the right help

Newham

- Enabling the best start through pregnancy and early years
- Supporting our young people to be healthy and ready for adult life
- Supporting people around the determinants of their health
- Developing high quality inclusive services, ensuring equity and reducing variation
- Meeting the needs of those most vulnerable to the worst health outcomes
- Creating a healthier food environment
- Supporting active travel and improved air quality
- Creating an active borough
- Supporting a Newham of communities where people are better connected and supported
- Working towards a smoke free Newham
- Building a borough of health promoting housing
- Building an inclusive economy and tackling poverty

Barking and Dagenham

- Best Start in Life
- Early Diagnosis and Intervention
- Building individual and community strength

*Note these are joint health and wellbeing priorities which may evolve as place based partnerships become more established

What engagement we have done so far

- We have engaged with various partners across NEL, these include Health and Wellbeing Boards, Place-based Partnerships, Provider Collaborative groups and Care Providers, as well as internal staff lunch and learn sessions.
- Acknowledgment that a lot of work has gone into the JFP, further work to be done on looking ahead in the future
- We have received **support of the NEL JFP direction of travel** and appreciation of seeing all the transformation plans in one place.
- Further work is needed to ensure that places and collaboratives can fully see their priorities reflected in the NEL wide plan.
- We are now looking to establish an on-going dialogue with our local people and wider partners to reflect their needs and priorities.
- We have created a summary version of our JFP which is more accessible to the general public.

6. Implications and next steps

Early lessons from work to develop this plan

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

Next steps for our transformation programmes

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

Technical work

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

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

Engagement

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

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

We will continue to evolve as a system

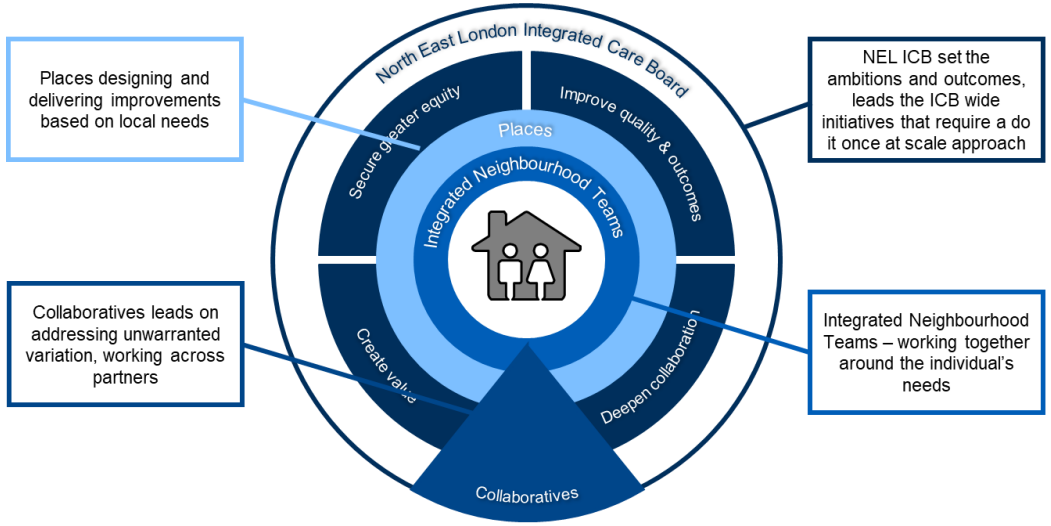
Our system has been changing rapidly over recent years, including the inception of provider collaboratives, the launch of seven place based partnerships, the merger of seven CCGs followed by the creation of the statutory integrated care board and integrated care partnership in July 2022.

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

- At **Place** delivering 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.

North East London Health & Care Partnership

Inner North East London JHOSC

12 July 2023

Title of report	Place partnership mutual accountability framework
Author	Charlotte Pomery – chief participation and place officer at NHS North East London
Presented by	Charlotte Pomery – chief participation and place officer at NHS North East London charlotte.pomery@nhs.net
Contact for further information	
Executive summary	This mutual accountability framework has been developed with north east London's place partnerships and aims to establish a common understanding of shared ambitions, mutual expectations, and way of working between place partnerships and other parts of north east London's integrated care system. It sets out the role of place partnerships in delivering the integrated care system's strategic objectives, alongside local priorities. It also contains metrics to underpin place partnerships' accountability for improving local quality and performance. It concludes by explaining how NHS North East London will support place partnerships in each of these areas. The provisions of the framework have been captured in updated terms of reference for the NHS NEL sub-committee in each place. A similar and interlinked framework for the Collaboratives is being developed with partners.
Action required	For information and discussion
Previous reporting	The mutual accountability framework was developed through joint work with each Place and incorporates a range of comments and feedback from Place Partnership and Collaborative Committee meetings.
Strategic fit	The mutual accountability framework is designed to support place partnerships to contribute to the achievement of all of the north east London's integrated care system's objectives: • to improve outcomes in population health and healthcare; • to tackle inequalities in outcomes, experience and access; • to enhance productivity and value for money; and • to support broader social and economic development.
Impact on local people, health inequalities and sustainability	North east London has a long history of successful place-based working. Strengthening and spreading this across the integrated care system is critical to our overall success because places are:

	• where the NHS, local authorities, and the voluntary and community sector integrate delivery, supporting seamless and joined up care; • where we will most effectively tackle many health inequalities through prevention, early intervention, and community development, including at neighbourhood level; • where diverse engagement networks generate rich insight into residents' views; • where we can build detailed understandings of need and assets on a very local basis and respond with appropriate support; and • where the NHS and local authorities as a partnership are held democratically accountable. This mutual accountability framework is designed to support place partnerships to fulfil these functions, in the interests of all residents.
Impact on finance, performance and quality	There are no additional resource implications (either revenue or capitals costs) arising directly from this report. However, the mutual accountability framework is designed explicitly to increase subsidiarity within north east London's integrated care system by empowering place partnerships with accountabilities across finance, performance, and quality.
Risks	There is a risk that, without clear articulation of the roles and responsibilities of each part of the integrated care system, partners will collectively not allocate resources and deliver transformation to best drive meaningful improvements to health, wellbeing, and equity in north east London. This document is, alongside complementary work being done on the accountabilities of other parts of the integrated care system, part of the mitigation of this risk.

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FINAL DRAFT, FOLLOWING FEEDBACK

North East London Health & Care Partnership

A framework for mutual accountability between north east London's place partnerships and NHS North East London

Introduction

North east London's place partnerships are uniquely placed to drive the integration between health and care that will improve local people's wellbeing, through co-produced approaches that build on community assets. As partnerships, they understand their communities and the inequalities that local people face. Reshaping north east London's health and care system so that it is equitable, delivers improved wellbeing for everyone, and is financially sustainable, will happen only if we work together to deliver at neighbourhood, place, collaborative, and system. Each element of the system needs to be accountable for its part of our improvement journey and to work together alongside local people and communities to effect change sustainably.

This draft document continues our discussion about what NHS North East London asks place partnerships to hold accountability for and, in turn, what the partnerships can expect NHS North East London to achieve for them. We recognise that place partnerships will also need support from a wide range of partners notably local authorities, NHS Trusts, provider collaboratives and the voluntary, community and social enterprise sector in order to achieve their potential. Support will come in various forms as the partnership is enabled by the strengths and contributions of each and every partner.

This document will sit alongside an equivalent document that focuses on the role of provider collaboratives to help build our understanding of how the system overall will work best.

We recognise that our system is new and evolving, and much of this draft document seeks to outline the principles which will guide this evolution to support improved health and wellbeing for local people.

Zina Etheridge – Chief Executive Officer, NHS North East London

Background

The North East London Health and Care Partnership (NELHCP) brings together the NHS, local authorities, and community organisations across north east London to work in partnership with local people to support them to live healthier, happier lives.

Our approach is built on an understanding that partnership, conversation, and collaboration underpin all that we do. We see that place shapes and strengthens system and that system enables and builds place, underlining our appreciation of the need for our workforce to participate through a range of inter-connecting networks (operating at neighbourhood, place, collaborative, system, region, and nation) in order to be most effective in improving outcomes for everyone. NHS North East London has adopted the principle of subsidiarity to encapsulate this approach as applied to governance, decision-making, strategy, and delivery of models of care. This means we will facilitate tasks being performed at the most local level, closest to those most likely to be directly affected, and only carry out tasks that cannot be carried out at that more local level.

As north east London's integrated care system, we are ambitious and actively draw on best practice locally and internationally. We are clear that we are moving beyond performance management to maximising value, and beyond our individual responsibilities to create a shared endeavour and mutual accountability for delivering benefit and opportunity for local people. We are

committed to continuous improvement and innovation across and with all partners, meaningful co-production and resident participation, and working in integrated ways together to provide better health and care outcomes for our growing and diverse population of over two million people. At the heart of our partnership is a shared commitment to meaningful participation with local people and partners, a passion for equality and addressing health inequalities, and ensuring that system collaboration underpins continuous improvements to population health and the integrated delivery of health and care services. To operate effectively, we understand that our system needs to develop continually, to be resilient, and to respond coherently and in partnership to emergencies and emerging challenges.

Our seven place partnerships and our five provider collaboratives are crucial building blocks of North East London's integrated care system. Together they play distinct but crucially interdependent roles in driving the improvement of health, wellbeing, and equity for all local people. As we mature as a system, we will increasingly call on each other to support the achievement of outcomes and to enable the collaboration and partnership on which we all rely. We recognise that this support will look different for different pathways but we recognise the fundamental importance of building relationships, sharing perspectives and working alongside local people to facilitate this support.

The places of north east London have a long history of successful place-based working. Strengthening and spreading this across north east London is critical to our overall success because places are:

- where the NHS, local authorities, and the voluntary and community sector integrate delivery, supporting seamless and joined up care;
- where local authorities can seek partner input into, and support for, their work to improve the wider determinants of health, which extends into areas including housing, education, employment, food security, community safety, social inclusion and non-discrimination, leisure and open spaces, and air pollution;
- where we will most effectively tackle many health inequalities through prevention, early intervention, and community development, including at neighbourhood level;
- where diverse engagement networks generate rich insight into local people's views;
- where we can build detailed understandings of need and assets on a very local basis and respond with appropriate support; and
- where the NHS and local authorities as a partnership are held democratically accountable, through health and wellbeing boards and overview and scrutiny committees.

Aligned to this, our collaboratives play a critical role in bringing together NHS provider trusts, primary care networks, and VCSE organisations across the whole of north east London to make use of their combined resources and expertise. We have collaboratives for acute care; mental health, learning disabilities, and autism; community services; primary care; and the VCSE sector. Across these five collaboratives, partners are focused on:

- reducing unwarranted variation and inequality in health outcomes, access to services and experience;
- improving resilience by, for example, providing mutual aid;
- ensuring that specialisation and consolidation occur where this will provide better outcomes and value;
- spreading innovation and best practice; and
- ensuring a strong voice for users of their services and other provision in ICS decision-making.

Principles for working together as place, collaborative, and system

- Our approach is built on a shared understanding of subsidiarity: that decisions are best taken closest to those most affected by them. There is freedom to lead, innovate, experiment, and deliver through place partnerships, without non-value-adding interventions from NEL-wide structures.
- Subsidiarity will be enabled by financial and functional delegation to place sub-committees and to provider collaboratives where required.
- Aligned to this is a shared belief that the place partnerships created in our new arrangements are equal partnerships, with organisations, including collaboratives, coming to the table as equal partners to improve outcomes for local people.
- Our model of working together sees place partnerships holding responsibility for the health and wellbeing of their local population across all age groups, for key local outcomes, for improving care and support, and for reducing health inequalities, calling on collaboratives and NHS North East London to support.
- Our ambition is for system to support the journey towards greater integration strategically and operationally, building on best practice in places and recognising this might look different in each place.
- We are committed to working from existing arrangements in each place to develop the capacity and infrastructure that best supports place partnerships to respond to the specific and varied health and wellbeing needs of their local populations.
- NHS North East London will play a role in facilitating partners across the patch to enable effective place working, including problem-solving with and on behalf of place partnerships, advocating for the centrality of place, and organising teams and processes in ways that recognise the relevance of place.
- NHS North East London supports the approach that places shape the system and the system shapes places, and will address behaviours that promote the idea of it as an organisation standing apart from places rather than built from them, such as how its teams communicate and how north east London-wide work is described.
- Place partnerships and provider collaboratives are equal and co-dependent partners in the improvement of health, wellbeing, and equity. They will frequently rely on each other to achieve their objectives. For example, provider collaboratives will often depend on place partnerships for the insight required to ensure that north east London-wide programmes of work meet the varied needs of communities across north east London. Equally, place partnerships will rely on provider collaboratives to leverage the capacity and expertise that enables local people to be cared for in the quickest and safest way possible. The links between place partnerships and provider collaboratives will come from the overlap of leaders, focused engagement on particular areas work, and formally through the population health and integration committee of the Integrated Care Board.
- Place partnerships will recognise their role within, and contribution to, the wider system in line with the principle of subsidiarity. This means that, whilst places work principally to respond to the needs and aspirations of their local people and communities, they will also work in alignment with co-created wider approaches and, along with provider collaboratives, to deliver local elements of wider programmes. Whilst some such approaches and programmes may span north east London, some may cover identified geographies within this or dedicated communities for example.

Delivering care and support that improve health, wellbeing, and equity

Our shared work to improve health, wellbeing, and equity combines outcomes and priorities identified by each place partnership with north east London-wide programmes in which places play a critical strategic and delivery role alongside collaboratives and NHS North East London.

We are already identifying clear and quantifiable outcomes goals – co-produced with local people – so that we can be clear about the impact we are making. Where these already exist, they will be at the front and centre of the outcomes model.

Area	Place partnership accountabilities
Overall ambition	Place partnerships will be responsible for the health and wellbeing of their local populations. In order to support this, a key role of place partnerships will be to convene a range of partners and enable their contribution to the delivery of integrated local care, based on smaller neighbourhoods and reflecting the system and community assets held locally. Each place will facilitate and co-ordinate the work necessary across collaboratives and geographies to ensure that all local people can access same-day urgent care when they need it and deliver continuity of care for agreed cohorts of local people in line with the Fuller Stocktake and any associated policy or legislative developments. Through prevention and earlier intervention, across the age range, focused on the wider determinants of health and wellbeing, place partnerships will help to reduce the proportion of the population needing the most acute health and social care, including hospital stays and residential and nursing care, creating health and wellbeing for a wider range of local people for longer. Partners will also work together in integrated ways to minimise pressure on the social care front door, including by promoting earlier intervention and the use of community assets that support local people to avoid reaching crisis. In the context of a rapidly growing population, this approach is key to moderating the growth in demand for both NHS health provision and local authority social care, which is critical to our system's long-term sustainability.
Leadership and infrastructure	Places hold a number of key strategic functions for the integrated care system, including: • relationships with local authorities, local providers, community groups, and local people; • participation and co-production with local people; • the insight to understand and tackle local population health and inequalities; • supporting system financial sustainability; and • building integrated models of insight, planning, and delivery. In order to fulfil these functions, places will need the resources identified in the proposal for core place teams, as well as support from north east London-wide teams who will provide embedded teams or individuals working at place. Places will be supported by an effective financial strategy and the requisite delegations for decision making. We envisage the leadership role at place as a system leadership role that builds on the strengths and assets of local communities and of our system, actively convening conversations, facilitating different perspectives, hosting partners to share best practice and building collaborative approaches. We will need to remind ourselves constantly of our system gaze, scanning a range of elements to build the strengths-based system we need.

Neighbourhood working	The place partnership will facilitate strong connections within each neighbourhood, building integrated teams encompassing NHS and social care services, the wider local government offer, and community-led care and support. Along with a central role for primary care, including the primary care collaborative, this joined-up locality working will strengthen the integration of health and care and directly drive better local outcomes. ➢ *How NHS North East London will help* Where a lack of geographical coherence of primary care networks poses a challenge to neighbourhood working in a place, NHS North East London will work with the primary care collaborative and places to support and drive the alignment of footprints to maximise the impact of neighbourhood working.
Partnership working	The place partnership will promote and enable the widest possible view of partnership working. This means working beyond statutory health and care organisations and ensuring that representatives from (for example) the voluntary sector, housing, and police are actively involved in the work of the partnership. This wide view of partnership includes a default to meaningful engagement of, and co-production with, local people. The place partnership lead and NHS North East London will together support the development of the partnership as a high-functioning executive team. This includes the encouragement of peer collaboration and constructive debate between partners, along with transparency and candour about organisational challenges. The Place Partnership Lead, the Director of Partnerships, Impact and Delivery, the Clinical Lead, and the collaboratives' leads in each place will together manage the business of the partnership as well as leading co-production, innovation, and the sharing of best practice. On safeguarding specifically, there is an important opportunity to join up existing statutory forums with the work of the broader partnership. Statutory arrangements are not affected by the development of the place partnership or the sub-committee of NHS North East London. However, the place partnership can play a vital role in facilitating the contribution of safeguarding leads' expertise into the broader agenda of the place partnership, including care model and pathway design. Equally, the place partnership can help to facilitate all partners' contribution towards additional preventative work across the safeguarding agenda. ➢ *How NHS North East London will help* NHS North East London will connect place partnerships with each other, including robust mechanisms to share learning and leading practice across place partnership leads, clinical and care professional leaders, and staff from all levels in partner organisations. NHS North East London will also provide elements of development support across the seven places, by agreement with the place partnership leads.
Mental health and wellbeing	The place partnership, working closely with provider collaboratives at place, will develop and, through its partners, deliver integrated services that enable local people, from children and young people to older people, with mental ill-health to live well in the community. This will focus on agreed priority cohorts and prioritise prevention and more equitable access to services. The place partnership lead will ensure a strong focus on the wider mental wellness agenda, including access to support for children and young people, access to employment and access to community-based care and support networks, rather than our collective historic default to focus on the acute end of mental health services.

Babies, children, and young people	Place partnerships, working closely with provider collaboratives at place, will make sure that north east London's places are the best places for babies, children and young people to develop and grow. Place partnerships will take an all-age approach, with parity between the needs of babies, children, young people, and adults, as the basis for sustainable long-term improvements to population health and wellbeing. The place partnership lead will drive creation of a coherent approach to early years, adolescents, and young people up to the age of 24, bringing in partners from across the NHS, local government (families, education, housing), and community organisations, working with parents and families and building holistic support for all babies, children and young people.
Workforce	The place partnerships will lead local design of more integrated workforce models, based around neighbourhoods and focused on community delivery by a broad range of clinical and care professionals alongside VCSE. Place partnerships will also enable local employment by forging effective links with local education and training institutions. The place partnership lead will sponsor this work whilst participating in, and facilitating broader place contributions to, NEL-wide work on broader systemic issues relating to recruitment, retention, design of new roles, and skills development across north east London.
Long-term conditions	Place partnerships have a significant role in ensuring a strong focus on prevention and early intervention, convening work across collaboratives, places and system and facilitating the creation of health-promoting communities and neighbourhoods. Partnerships will support the co-ordination of end-to-end pathway responses for local people at risk of and experiencing long-term conditions, working at different geographies and across different age cohorts to facilitate the best outcomes for local people and communities. Please see the annex for further detail.
Community-based care	Place has a significant role in co-ordinating care in the community, ensuring a strong focus on prevention and early intervention, working across collaboratives, places and system and creating health-promoting communities and neighbourhoods for all. Much of the focus will be on a multi-agency approach to Ageing Well, ensuring that north east London is a good place to age, for example with dementia-friendly policies which could be met by the all-age approach supported by place partnerships. Place partnerships will seek to ensure local people can be supported at the end of their lives, dying with dignity in the place of their choice. This could include ensuring good information, advice, and guidance, palliative care at home, effective community support, and residential options are all available, reflecting the cultural and specific needs of our diverse populations. Place partnerships will ensure informal carers are well supported through the experience of end-of-life care for their loved ones. Please see the annex for further detail.
Learning disability and autism	Recognising the leadership role for local authorities in valuing people with learning disabilities and autism to lead fulfilling lives, place partnerships will bring together partners at a place level, including to improve the levels of employment, independent living, and quality of life for people with a learning disability. Place partnerships will enable good system working and ensure the needs of people with learning disabilities and autism are considered across all pathways.

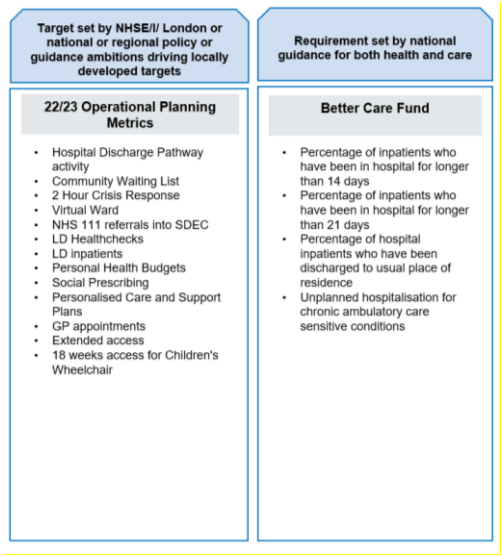
	Place partnerships will work with all partners to seek to ensure people with learning disability and autism do not experience inequality of outcomes across any health or wellbeing domain, as reflected here and in performance and quality metrics. Place partnerships working across partners will be accountable for improving the rates of Learning Disability Health Checks carried out annually, and how the outcomes of these checks are followed through. Place partnerships will work with the Mental Health, Learning Disability and Autism Collaborative to ensure that Transforming Care responses are timely and support the principles of independent, community-based living for this cohort.
Carers	Place will play an active role in facilitating and joining up work across partners to ensure that carers are valued, supported to care, and able to enjoy fulfilling lives beyond their caring responsibilities. This will include developing a joint carers' strategy and action plan, as well as delivering on the NHSE metrics and deliver against specific targets on carer assessments, commissioning carer support agencies, etc. Place partnerships will work with local authority leads to ensure carers' strategies reflect wider system working and build awareness of the need for identification and support to carers to be system-wide. Place partnerships will deliver strengthened carers' offers that reflect the needs of their local communities and build best practice.
Homelessness	Recognising the leadership role of local authorities, place partnerships will be responsible for improving the health and wellbeing of those sleeping rough or facing homelessness by: • ensuring GP registration and primary care support to this cohort; • improving access to secondary and tertiary care as appropriate; • recognising the needs of the homeless population for all levels of support, care, and treatment across mental and physical health; and • co-ordinating local support to the street homeless population and participating in work led by local authorities work to improve their health and wellbeing outcomes.
Asylum seekers and refugees	Recognising the leadership role of local authorities, place partnerships will be responsible for improving the health and wellbeing of asylum seekers and refugees, including those accommodated in Home Office hotels, by: • ensuring GP registration and primary care support to this cohort; • improving access to secondary and tertiary care as appropriate; • recognising the needs of the asylum seekers for all levels of support, care, and treatment across mental and physical health; and • co-ordinating local health and wellbeing support to the asylum seeker and refugee population and participating in work led by local authorities to improve their health and wellbeing outcomes.
Person-centred care	Place partnerships will be held accountable for enabling person-centred care in their local area. This will include bringing together a range of initiatives that support local people and communities to be at the centre of decisions that are made around their care, reflecting the principle of 'Nothing about us, without us'. Ways of testing effectiveness in this area could include rates of satisfaction and levels of personal health budgets and direct payments in a specified area and for specific communities.
Health creation and primary	Place partnerships will lead for ensuring that the wider determinants of health are effectively understood and influence approaches to all areas of

prevention	accountability. Place partnerships will lead on the involvement of the whole local authority and wider partners to build an effective model for addressing wider determinants and their impacts on health and wellbeing. Place partnerships will be held accountable for supporting models to reduce health inequalities and improve health and wellbeing through a series of performance and quality metrics, attached.
Immunisations	Place partnerships are key in enabling uptake of immunisations across all communities in a local area. They will be accountable for the vaccination and immunisation rates of their local population, across children and adults and for routine and reactive vaccination programmes. Places will be required to ensure capacity for all vaccination and immunisations activity and to support take up with a focus on inequalities and ensuring equitable take up across all communities.
Local system flow	As the principal forum for local health, care and wellbeing partners, place partnerships have a critical role in addressing more immediate operational pressures whose resolution require input from multiple organisations. The place partnership lead will ensure that place-based mechanisms exist to convene relevant partners as required to maintain consistent and adequate system flow, as well as to respond to periodic additional pressures. This will be with the support of the relevant commissioning and transformation teams from within NHS North East London and will ensure the pressures on all parts of the system are paid equivalent attention.

Accountability for improving performance and quality at place

Many of the performance and quality metrics – and related outcomes for local people – that NHS North East London is required to deliver can be achieved only through effective collaboration in place partnerships. Each partnership is working on a performance and quality metrics framework that will set out in greater detail the metrics for which place partnerships are responsible and will be held accountable, whether the lead is with the NHS, the local authority, or other partners.

These metrics are a combination of performance and quality metrics contained in NHS North East London's operating plan, which is agreed each year with NHS England; the Better Care Fund Plans approved by Health and Wellbeing Boards in each local authority area; and in place partnership delivery plans, based on locally-identified priorities. The partnership will monitor performance and quality, identify trends and clusters of concern, agree and implement corrective action where necessary, and sense check data quality, with the support from the relevant local and north east London-wide commissioning and transformation teams from NHS North East London.



How NHS North East London will help

NHS North East London will direct its people to work with place partnerships to develop their approaches in each of the areas described above, specific to the local context. This includes offering the tools, capacity, and skills required. It will build up north east London-wide approaches from work done at place. These north east London-wide approaches will aim to remove systematic barriers which obstruct effective place-level work. It will also work with places to direct additional available financial resources to support work in these areas.

In this role, NHS North East London will also work across the system to enable the contributions of partners including NHS Trusts, the provider collaboratives and local authorities to each place partnership to enhance their understanding and delivery.

Additional commitments from NHS North East London:

Theme	Commitment
Localism and subsidiarity	• NHS North East London will operate, and shape the wider north east London health and care partnership, around a *default to place* – the assumption that places (and neighbourhoods within them) are the optimum organising footprint for our work unless there is a clear reason for operating at a larger scale • NHS North East London will provide its leaders at place with sufficient autonomy and flexibility to work in the ways required to deliver for their places, as well as encouraging and enabling this way of working in provider trusts • NHS North East London will ensure the ICB Board effectively delegates to Place Sub-Committees the functions and financial influence required to deliver its accountabilities – with an objective of this coming into place from 1 April 2023, with the requisite place-level engagement on new sub-committee terms of reference approvals happening in advance of this
Capacity to deliver	• NHS North East London will lead all partners across the health and care partnership to devise an integrated workforce strategy that sets out how the workforce needed in each place will be delivered • NHS North East London will organise its own workforce so that it supports the work of each place partnership, including through a core team based permanently in each place and an extended team at place drawn from colleagues working in NEL-wide structures • NHS North East London colleagues who are part of the extended team will spend time in the places to which they are aligned, building local knowledge and relationships • NHS North East London will encourage other partners who work across multiple places to align their structures and teams to place partnerships, where this supports delivery of place partnerships' objectives • NHS North East London will fund the substantial portion of clinical and care professional leadership roles operating at place
Money	• NHS North East London will lead the codesign of a system-wide financial strategy, including place partnerships, which will move investment into community health services and support the transformation required for place partnerships to deliver their objectives • This will include NHS NEL working with partners to agree the

	specific budgets for which place sub-committees hold responsibility, along with and the associated requirements (such as reporting and treatment of over/under-spends). NHS NEL's objective is that, subject to system agreement, place sub-committees take on these responsibilities during the 2023/24 financial year (potentially at different points in the year for different places), with all places responsible for delegated budgets ready for the 2024/25 planning round • An underpinning principle of the financial strategy will be that allocations are made to trusts and place sub-committees on the assumption of active and meaningful engagement with partners in how they are invested, through the place sub-committees and the broader place partnerships as well as through the provider collaboratives • NHS North East London will support the development of a strategic overview of all funding enabling health and wellbeing in each place – including money spent by the NHS, local government, the direct schools grant and other education spending, and other public services – to create the insight required for each place partnership to exert influence across a greater spread of relevant investment • NHS North East London's financial strategy will drive a levelling up agenda so that the money spent on health services in each place is increasingly in line with relative need and reflects the pressures of population growth
Data and insight	• NHS North East London will provide place partnerships with the shared data and insight collectively agreed to be required to improve local outcomes, focused on outcome measures, service performance, and the information needed to plan and evaluate local transformation work • This will be in the form of a defined data set agreed between NHS NEL and the place partnerships • As part of the financial development programme, NHS NEL will lead the co-design of a suite of reports and tools that support discussions between place partners within places about the best allocation of capacity. These will include benchmarking of finance and performance and operational data and support transparency within and between places. • NHS North East London will provide capacity for bespoke local analysis commissioned and directed by place partnerships • NHS North East London will also lead on working across partners to resolve issues that inhibit effective provision and sharing of data, including information governance, conflicting data sets, and unclear points of contact

Annex

We recognise that there are some specific areas where place partnerships and collaboratives working together will need to determine by pathway how we best enable population health and wellbeing.

Examples of areas where we may work to define roles in more detail include:

- **Long Term Conditions**
  - In addition to the roles and functions outlined above, places could be required to:
    - understand local needs, have insight into local communities and plan for future needs;
    - deliver engagement and outreach into our diverse communities to build awareness and community support;
    - innovate to deliver primary and secondary prevention;
    - identify and manage long-term conditions;
    - develop integrated teams that support people with rising and complex needs, which will encompass a lot of long-term conditions management (Fuller);
    - empower patients to manage their own health as far as possible;
    - support people to live independently and well at home, avoiding admission to hospital or long-term care;
    - develop out of hospital services that support people with long-term conditions;
    - implement a consistent community-based rehabilitation offer; and
    - share best practice, identifying opportunities to work on a cross-borough basis and making pathways into secondary care as simple as possible.
- **Ageing Well**
  - In addition to the roles and functions outlined above, places could be required to:
    - understand local needs, have insight into local communities and plan for future needs;
    - deliver engagement and outreach into our diverse communities to build awareness and community support;
    - innovate to deliver primary and secondary prevention for older local people and those in need of community-based care;
    - develop integrated teams that support people in need of community-based care, aligning with implementation of the Fuller Stocktake;
    - empower patients to manage their own health as far as possible;
    - support people to live independently and well at home, avoiding admission to hospital or long-term care;
    - develop out-of-hospital services that support and are accessible to local people;
    - implement a consistent community-based rehabilitation offer; and
    - share best practice, identifying opportunities to work on a cross-borough basis and making pathways into secondary care as simple as possible.

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North East London Health & Care Partnership

INEL JHOSC

System recovery and resilience in the Urgent and Emergency Care (UEC) programme

Purpose of this pack

North East London Health & Care Partnership

This pack provides a summary of our system resilience planning. It sets out our overall approach to our system resilience programme and governance as well as more detail on our planning across the catchment area.

- The system has been placed in Tier 1, and a particular focus for this is the services covered by BHRUT (mainly serving Barking, Havering & Redbridge)
- Slides 3 and 4 - outline the principles that are informing our governance.
- Slide 5 - our high level system ambition for resilience.
- Slide 6 - our system plan on a page (note that we are considering with partners whether the language works to enable everyone across the system to understand the plan)
- Slide 7 – The Tier 1 support. Outer NE London, specifically Barking, Havering and Redbridge (BHR - which largely form the catchment fort BHRUT) is the most challenged part of our UEC system and we have developed an improvement plan specifically focussed on community and place based action in this part of our system
- Slide 8 – is our plan on a page for BHR (the detailed plan to be considered in ONEL)
- Slide 9 – the plan for 111 services in NE London
- Slide 10 – our overall plan is intended to improve the overall responsiveness of the UEC system to deliver better outcomes for NEL residents and more detailed planning underpins it. This section of the pack provides an illustrative deep dive into two areas which are particularly important for flow across the system.
- Slides 11 – ambulance handovers
- Slide 12 – Improving the responsiveness to patients in emergency departments requiring mental health support

Purpose and intent of our programme governance

North East London Health & Care Partnership

- As a ICS, our programme governance for UEC brings together all the improvement work delivered through our Place Based Partnerships, Provider Collaboratives and NEL programmes (for example Fuller)

- Our UEC programme will be the single point of focus for our improvement work, responding to all Regionally and Nationally mandated plans and assurance including

    - National Tier 1 reporting
    - National UEC Recovery Plan
    - Any nationally mandated winter plan

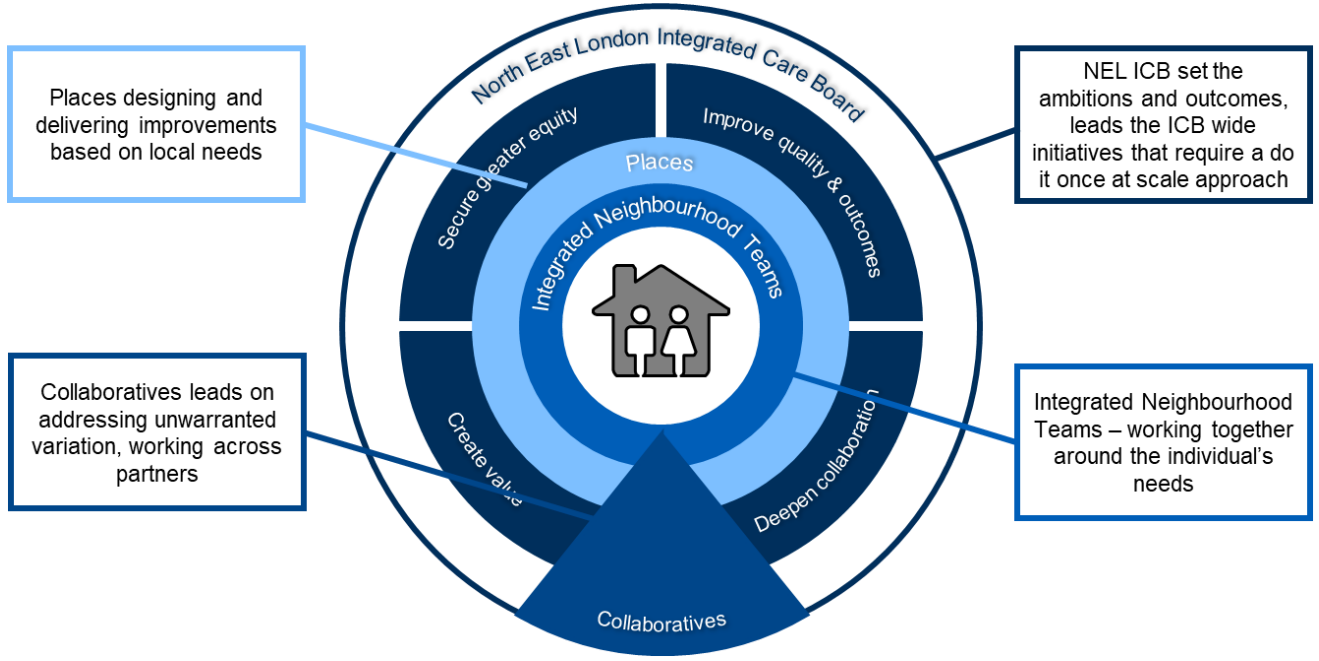
- Our UEC programme will be organised around five strategic system goals; our programme governance will ensure that delivery of individual improvement projects are overseen through either Places or Provider Collaboratives with clear accountability and reporting up to our UEC Programme Board

- Leadership of our UEC programme will clarify accountability of named individuals, working on behalf of the system

- Clinical / Subject matter experts will continue to be strongly aligned to the programme structure

Principles of our programme governance

- We will adopt the principles of the ICS operating model in our UEC programme governance
- Our governance will be designed around teams working
  - 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 programmes will be 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.



Our system ambition for UEC

North East London Health & Care Partnership

Improved access to urgent and emergency care for local people that meets their needs and is aligned with the UEC national plan.

We have defined what resilience looks like for the short and long–term:

Winter 23/24: Stabilisation of the provision of safe, accessible care.

Long-Term: Sustaining a UEC System that is focused on keeping people well, meeting the health needs of the population, ensuring easy access to care where required in the community, with efficient flow through acute care when required, supported by a workforce that operates without being overwhelmed.

Prevention of conditions and support needs

Prevention will be addressed in the future of the UEC SRR

Goal: engaging in proactive population health management to keep people well in the community.

Management of existing conditions and needs

Timely intervention for escalation of needs or new needs and conditions

Goal: strengthening the provision and access of alternative pathways to reduce UEC footfall and attendance.

Goal: optimising flow through Acute trust sites.

Timely and effective return to community setting following escalation

Underpinned by **data, governance, workforce and effective pathways**

Goal: setting up the systems, governance, workforce and pathways necessary to form a sustainable plan and work as a system.

Our system outcomes for UEC

North East London Health & Care Partnership

Strengthening the provision and access of alternative pathways to reduce UEC footfall and attendance	
Outcomes	Improving same day access to primary care
	Supporting Community Pharmacies to increase their care provision
	Promoting awareness of different care pathways and services across NEL to residents and the system
	Improving alternative pathways to encourage attendance avoidance

Optimising flow through Acute trust sites	
Outcomes	Improving discharge processes
	Increasing capacity by improving processes and productivity
	Releasing capacity by increasing redirection to primary and community care

Engaging in proactive population health management to keep people well in the community	
Outcomes	Proactive and/or targeted intervention
	Ensuring consistent care across the system
	Empowering citizens to manage their health

Setting up the systems, governance, and pathways necessary to form a sustainable plan and work as a system	
Outcomes	Facilitating delivery of joined-up care across the system
	Increasing transparency by leveraging data
	Standardising care by defining best practice pathways
	Creating accountability at all levels through collaborative governance structures.

Metrics
76% of patients meeting the 4-hour wait standard
Ambulance handover standard time of 15 min
Waits <2 hours
No criteria to reside
MH patient waits in ED (max. 12 hours) and general acute wards

Tier 1 status

The NE London system has been designated as Tier 1, requiring the highest of intervention and support from the national UEC team. It is expected that Tier 1 status will complement the existing SOF4 process for BHRUT.

A particular focus of the national team will be the Winter Plan for 23/24 with collaborative programmes being launched in July 2023.

NE London has also commissioned its own review of the 22/23 Winter Plan, and what will provide the maximum benefit for the coming year.

There are three areas of particular focus for improvement:
- Waiting times for patients in ED
- Speed of ambulance handover for patients arriving at hospital
- Rapid placement of mental health clients arriving at hospital ED

In general, the national UEC team wishes to join in with existing local systems and processes, rather than construct an additional layer of governance and reporting

The BHR locality plan summary is shown on the next slide for information

Summary of BHR Locality Improvement Plan

A detailed plan, managed at Place, to improve quality and speed of access involving all local partners

North East London Health & Care Partnership

Keeping people well
Enhanced offer to Care home residents
Implementation of Falls and Catheter care services
UCR – 2 hr response, cars, trusted assessor, therapy in ED
Alternative pathways – Physician Response Unit, REACH

Avoidable admissions – same day
GP access hubs
Delivery of PELC CQC action plan
Virtual wards – Frailty & ARI
Management and Support of High Intensity Users

Improving Hospital Flow
Discharge Hub
Delivery of BHRUT CQC Action Plan
Same Day Emergency Care

Discharge
Improve Pathways - Integrated Discharge Hub, Rehabilitation, Discharge to Assess, Homelessness
Welfare checks and reducing readmission
Capacity of Community Rehabilitation beds
Demand for reablement

111 services

Services currently provided by the London Ambulance Service (LAS), which includes call handling, initial triage, and clinical assessment.

The existing 5-year contract (annual value £20m) expires in July 2023 and an extension of up to 2 years has been agreed

The national UEC recovery plan, published in Jan 2023, indicated that a review of 111 services would be commissioned. This is expected in July 2023 along with detail on the scope of the national study

The volume of calls to 111 in NE London (and nationally) were higher than expected when the service was established, along with higher than expected costs. The ICB is working with LAS to improve the existing service through improved patient pathways and will establish a project team to design, specify and tender for the future service. This will be undertaken in close co-operation with primary care.

North East London Health & Care Partnership

Focus on two key flow issues – Ambulance handovers and mental health in ED

We have activity across the areas identified in our system resilience plan – more detail is provided here on two key flow issues.

Ambulance Handover Improvement

North East London Health & Care Partnership

- The impact that extended ambulance handover times has on the ability of the ambulance services (LAS and EoE) to respond in a timely manner to emergency calls within the community is recognised within NEL. Acute Trusts are participating in a workstream as part of the Acute Provider Collaborative (APC) UEC Programme.

Handover process and PIN compliance
Collaboration with LAS on PIN entry process
Named point of contact on each acute site for LAS escalation
Joint process for validation of handover times
SOPs for each site for process and professional standards

Reducing conveyance rates to ED
Make full use of REACH and PRU opportunities
Extended role of HALO in utilising community pathways
Direct ambulance access for Same Day Emergency Care

Specific BHRUT and LAS collaboration
Secondment of LAS manager to Queens site to review processes
Reducing patient processing time in RAFT units within ED
Extension of discharge unit to accommodate patients requiring beds
Weekly problem-solving meetings of LAS EoE and BHRUT

Mental health flow and length of stay

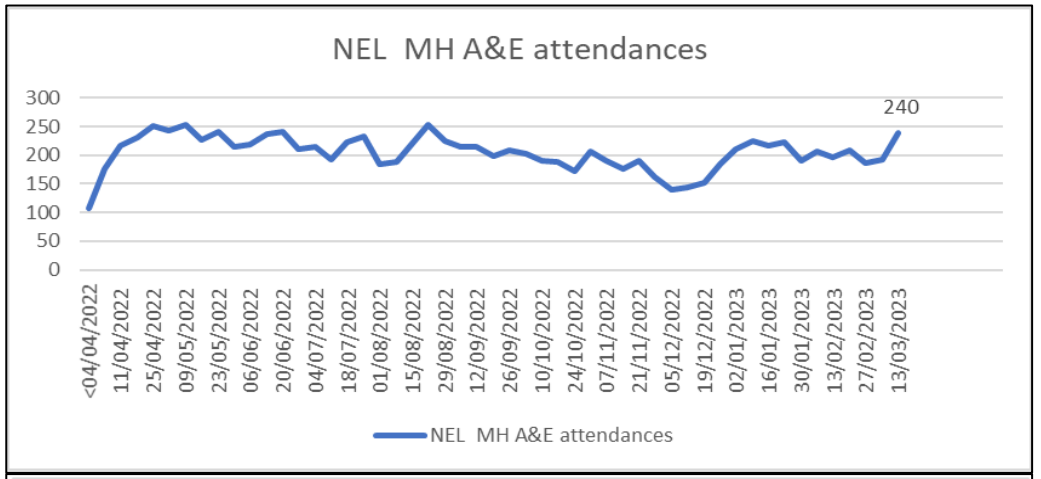
We have a programme of improvement work being delivered through our MH Crisis / UEC Improvement Network. Some high-impact schemes aiming to improve flow are:

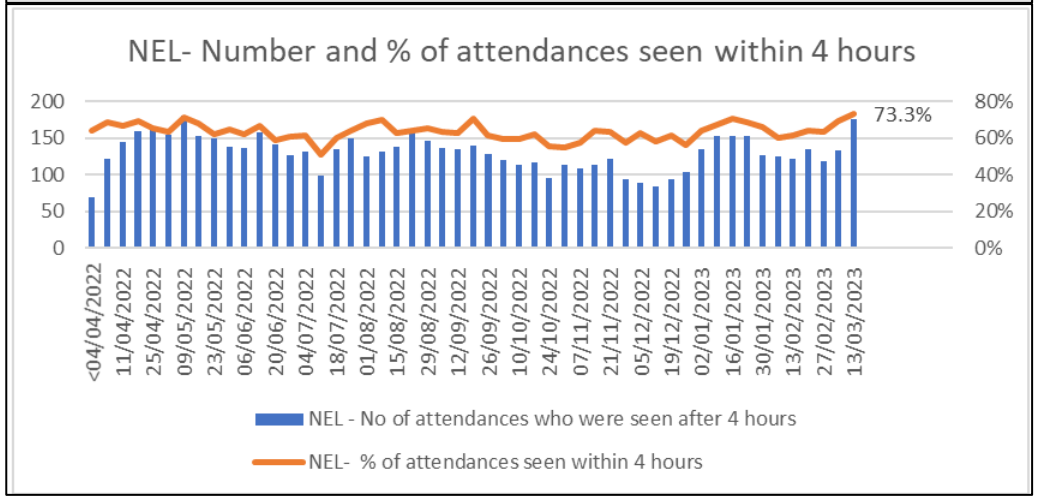
An expansion of our acute MH bed base by opening an additional 12-bedded acute MH inpatient ward	A demand and capacity review of our Psychiatric Liaison Services, and an audit to explore underlying themes in cases of 12hr breaches
Improvement work to our Health-Based Place of Safety estate, with additional staffing to ensure timely handover	An additional Clinical Decision Unit opened demonstrating a much reduced length of stay

We know that for both ELFT and NELFT, the average **LoS has increased over recent years**, and staff are reporting **higher acuity and complexity of needs** in those admitted (supported by data indicating higher proportion of admission under MHA).

With regards to MH in ED, there are a multitude of reports describing admissions and length of stay in A&E, but there **does not appear to be a 'single version of the truth'**. We are establishing a NEL MH in ED Data Working Group to build some shared and validated reporting, and to share the learning from BHRUT and NELFT where they have made real progress in this area.

North East London will be Tier 1 status of the UEC Recovery programme. We know this will bring additional focus on MH waits in ED, so it's more important than ever that we have a shared perspective on this.





Key upcoming events:

30th June – MH in ED Data Working Group

19th July – MH in ED System Flow Event

NHS
North East London

Continuing Healthcare Policies for North East London

Continuing Healthcare

- NHS Continuing Healthcare (CHC) is a package of health and social care for adults that is funded by NHS North East London
- There is no specific diagnosis to qualify for CHC and each case is looked at by a multi-disciplinary team to determine ‘Primary Healthcare Needs’.
- Most individuals have significant on-going health needs[1] or are at the very end of their life.
  - a patient might have with severe dementia, be physically able and often aggressive so that they need ongoing (and probably full time) intensive support to prevent them harming themselves and/or others
  - a patient might need a machine to be able to breath or have disorders of consciousness that require constant attention and observation
  - a patient might be at the very end of their life; with weeks or short months (typically up to 3 months) to live. They might be rapidly deteriorating with cancer or multiple illnesses and want to die at home but need support to do so with dignity.

[1]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1079650/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care_july_2022_revised.pdf

Why do we want to introduce new policies?

The development of these policies that apply to everyone across NE London (NEL) would enable NHS North East London to:

- put individuals at the centre of decision-making and support a culture of partnership between individuals, carers, families and partner organisations, where everyone understands the expected ways of working
- ensure all agencies and staff follow the National Framework and agreed local policies and processes
- ensure everyone is treated fairly and receives a consistently high-quality service
- reduce inequalities.

Four policies have been looked at and revised.

The majority of the polices are set by national legislation

There is no expectation that introducing these standard policies would reduce the budget available to patients or generate savings.

1. Placement Policy

This describes NHS North East London's (NHS NEL) and local authority partners' approach when placing and supporting eligible individuals in the community. This policy was developed in Havering, consulted upon, and is in use in Barking & Dagenham, Havering and Redbridge. Other areas of NEL do not have a similar policy.

- The policy aims to ensure a person-centred approach is taken in making decisions about a care package and that the individual or their representative is at the centre of discussions.
- It aims to ensure CHC packages of care are sufficient to meet the individual's needs; removes confusion about people's rights; standardises processes to reduce inequalities; and describes key issues – for instance when care packages will be reviewed and how disagreements will be resolved.
- It explains when a care home may be more appropriate than care at home; and how NHS NEL will assess and ensure that providers are able to provide appropriate care, provides safe and sustainable care, and value for money.
- ***For example:*** If a family of a patient identifies care at home that is more expensive than care in a care or nursing home, the policy provides guidance on whether this could be funded.

2. Joint Care Package Arrangements and Funding Policy

This policy describes NHS NEL and local authorities' approach to jointly funding care for a person in the community when they don't qualify for other elements of NHS Continuing Healthcare but they still have a health need that can't be met with existing services.

- There are draft versions of this policy in NE London, but there is no final policy in use.
- The purpose of the policy is to provide a standard way of working so that all staff work in the same way; and so individuals and their family/carer(s) understand the process and can make their wishes known.
- The policy sets out principles for packages of care and the health needs that qualify for joint care packages; how funding requests will be considered and decisions taken; how disagreements will be resolved; and how care plans will be developed and reviewed
- ***For example:*** When a patient care package requires the administration of medicines by a qualified medical professional, but that service isn't provided by the NHS or other parts of NHS Continuing Healthcare, this policy would consider how best to provide the service.

3. Dispute Resolution Policy and Protocol

This describes the approach taken to resolve a dispute when health staff and social care staff can't agree if an individual is eligible for Continuing Healthcare funding , whether there is a need for NHS-Funded Nursing Care, or about joint funding arrangements and refunds.

- Disputes and the use of this procedure are expected to be only in exceptional circumstances. Most issues are resolved quickly at a local level.
- The policy does not apply to disputes between NHS NEL and the individual or their representatives applying for Continuing Healthcare funding. These are resolved through a process described in the national framework.
- Agreement of a policy would enable local authorities, individuals and their families to understand the process and the expected timescales; would mean that individuals are treated equally and fairly; and would protect an individual's health and care whilst staff agree funding arrangements.
- ***For example:*** When there is a disagreement between the social worker and CHC Nurse about scoring of one or more CHC care domains, which impacts the patient being eligible for CHC funding or not, the Dispute Resolution policy will provide a framework to resolve such situations as well as provide case examples for staff training and quality improvement

4. Planning and Respite Policy for CHC Eligible Individuals Receiving Care at Home

The policy describes the process of care planning and how individuals and family/carers will be able to participate in the discussions of how an individual's assessed need can be met.

This policy recognises the significant contribution that family members and friends make to the care of those with a range of needs and describes the approach to planning and arranging care when an individual's unpaid carer needs a planned or unplanned break from their caring responsibilities (this is called 'respite').

- There are draft versions of this policy in NE London, but there is no final policy in use.
- Except in an emergency, a carer is required to give at least two weeks' notice of the intended respite period, so that appropriate alternative care can be arranged.
- The policy also sets out the process if the carer and the individual wish to take a holiday together.
- ***For example:*** A young adult with a learning disability who is cared for the majority of the time by their parents. The parents apply for respite in order to rest and relax and NHS NE London pays for relief carers in order for the parents to take a holiday.

Next steps

- NHS North East London has discussed the suitability of a public consultation with local Healthwatch and Directors of Adult Social Services. The view is that a consultation would not be beneficial:
  - The service is not changing – the policies aim to introduce better working practices, more consistency, better alignment with national legislation etc
  - It is unclear where public input could be incorporated, given the alignment with national guidance – this might raise expectations unreasonably.
- The preferred next steps are to:
  - Invite comments from key stakeholders e.g. JHOSCs, Healthwatch, charities – to check that the policies are correctly developed and explained
  - Develop a public awareness campaign – making the policies more user friendly for individuals and their carers/families, so everyone can understand their rights and responsibilities. E.g. We could commission short videos on CHC generally, and each of the policies, with subtitles in different languages.
  - Engage with those who have been recipients of (or involved in) the CHC process and ask what the system could do better.
- JHOSCs are asked to agree this way forward.

NHS
North East London

North East London Integrated Care Board Care Planning and Respite Policy for Continuing Healthcare Eligible Individuals Receiving Care at Home

FINAL DRAFT for consultation

Table of Contents

1 Aims and Values

1.1 The North East London Integrated Care Board (NEL ICB) have a vision to create a simpler more joined up health and social care system; one where the people of North East London have a consistently high-quality experience of health and social care and do not see organisational boundaries. Instead, they experience a 'system' where they see familiar faces that are clearly connected to each other regardless of where people are seen; be that in hospital, the community or at home.

1.2 NEL ICB will achieve this vision by working collaboratively and in partnership with their local authorities (LAs) and other health colleagues to ensure that they are providing the people of North East London with fair access to care planning and respite services which ensures better outcomes, better experiences, and better use of resources.

1.3 In order to standardise the delivery of services including care planning and respite services, NEL ICB, with its partner organisations have developed a single standard operating procedure (SOP) for CHC which will include this policy. This is to ensure that all organisations and staff involved in the arrangements for care planning and respite care for individuals receiving care at home, understand and agree to follow this process and put the individual and their needs at the centre of the process and deliver care consistently and fairly.

2 Introduction

2.1 NEL ICB and its local authority (LA) partners recognise the significant contribution that family members and friends make to the care of those with a range of needs. Through their support many adults are able to remain living at home for longer, preventing the need for institutionally based care for as long as possible and significantly improving the outcomes for the individual.

2.2 The National Framework for NHS Continuing Healthcare & Funded Nursing Care July 2022 (National Framework) defines a carer as:

> ***"anyone who, usually unpaid, looks after a friend or family member in need of extra help or support with daily living, for example, because of illness, disability, or frailty." (Annex A Glossary).***

2.3 The Care Act 2014 identifies local authorities as the responsible body for carrying out Carer's Assessments. The individual's Case Manager from either NEL ICB or the LA should make the necessary referral to the relevant LA or department if they believe a carer needs support. This must be done following consent from the carer.

3 Scope

3.1 This policy applies to family and friends who provide unpaid care to individuals aged 18 or over who are eligible for CHC and are living at home.

3.2 This policy describes how care arrangements will be identified and funded for the individual when their carer takes respite from their caring responsibilities.

3.3 This policy does not cover direct support to the carers whose needs will have been identified through their own care and support plan.

3.4 Furthermore, this policy does not apply to CHC eligible individuals living in supported living accommodation, residential or nursing care as their care provision is delivered by paid carers in those settings.

4 National Policy Context

4.1 Both carers and those with care needs have rights set out in law and described in the guidance that the local authorities and NEL ICB have to consider, specifically:

- The Care Act 2022
- The National Framework for NHS Continuing Healthcare & Funded Nursing Care July 2022.

5 Care Planning

5.1 Following a CHC eligibility decision, individuals, and their family or representative will be invited to participate in a person-centred care planning discussion with their CHC Case Manager. This will be an opportunity to discuss and agree how the individual's assessed needs can be met.

5.2 This is an opportunity to hear and understand the individuals care preferences and wishes and consider how they will be incorporated into the care plan. This is a critical aspect of our care planning process but is even more important when the individual is living at home with other family members.

5.3 Where the individual lacks capacity to make decisions on their care arrangements then an advocate should be considered to ensure that the individual's views and best interests are protected. Where this is the case it must be clearly documented in their care plan and all decisions must be in the individual's best interests.

5.4 The National Framework states that where individuals need ready access to support and/or supervision, Integrated Care Boards (ICBs) should consider, in the first instance, if such needs can be met by assistive technology. Family and friends may choose to provide some elements of the assessed care needs. If so, this will be clearly documented in the individual's CHC care plan.

5.5 Eligibility for CHC is based on an assessment of the individuals care needs. The care plan will then reflect the care required to meet those needs.

5.6 The CHC Case Manager will evaluate the risks of the individual being left alone and whether they need supervision and support at particular times of the day and/or night. If supervision and support is required the care plan will document when this is required and whether this will be provided by family as informal carers or by paid agency carers commissioned by NEL ICB and the exact nature of the intervention that will be provided.

5.7 NEL ICB has a responsibility to:

- ensure the individual's needs are met safely
- act in the person's best interest and
- spend NHS funds in an equitable and cost-effective way.

This is particularly relevant when considering a package of care at home provided by paid carers or a placement in a residential facility or nursing home.

5.8 Whilst due consideration will be given to the individual's and/or their family's preferences of providers of paid care, NEL ICB will aim to commission care from providers on the Any Qualified Provider (AQP) Frameworks for Nursing Homes and for Domiciliary Care.

The AQP Framework includes a range of domiciliary care agencies and nursing homes that have been,

- vetted by the NHS.
- are registered with the Care Quality Commission (CQC).
- employ carers with the necessary skills to meet the needs of individuals.
- have agreed rates of pay with NEL ICB.

Requests for care from providers who are not on the AQP Frameworks will only be considered on a case-by-case basis in accordance with NEL ICB's policies and procedures.

5.9 The care plan agreed following a person-centred conversation with the individual and/ or their family will be used by NEL ICB to provide the individual with a personal health budget (PHB) which can be used to purchase the necessary care.

The individual's indicative PHB allocation will be based on rates agreed for providers on the AQP Framework.

5.10 All CHC eligible individuals living in their own home will have a notional PHB in the first instance. This means they have been closely involved in determining their care needs and goals and know the cost of the care. However, NEL ICB holds the budget for this care and commissions it directly for them.

5.11 Personal Health Budgets can also be provided as a direct payment or third party PHB. individuals who are interested in exploring a direct payment or third party PHB can be supported by NEL ICB's PHB Team upon receipt of a referral from the individual's CHC Case Manager.

5.12 A direct payment PHB is when the individual is given the money to buy their care and support agreed in the care plan. The individual or their representative must show what the funds have been spent on and is responsible for buying and managing services needed as part of the care plan.

5.13 A third party PHB is when an organisation is legally independent of the individual and the NHS (for example, an independent user trust or a voluntary organisation) holds the money for the individuals, and also pays for and arranges the care and support agreed in the agreed care plan.

5.14 There may be some instances where the individual has personal assistants (PAs) from their previous local authority funded personal budget and wishes for these PAs to continue to provide care of them via PHB Direct Payment once they become CHC eligible. NEL ICB will explore such arrangements on a case-by-case basis and in all cases try and maintain a continuity of care where possible.

6 Care Arrangements When a Carer is having Respite

6.1 When family or friends choose to provide care to meet an individual's assessed needs, the CHC Case Manager will also assess the carer's ability to continue in this caring role. The Case Manager will confirm that the responsibilities on the carer are appropriate and sustainable (para 326, pg 86, The National Framework).

Contingency plans should be agreed with the individual and their carer for emergencies or if the carer is unexpectedly unable to continue in their caring role. This should be documented in the individual's care plan.

6.2 It is expected that the carer will need some planned respite from their caring role during the course of the year to take a break, attend important appointments or simply spend some time in the home without their caring responsibilities.

On such occasions, NEL ICB will make arrangements for the care of the individual. In anticipation of this need, the Case Manager will incorporate into the care plan for the individual to be cared for in their own home by paid agency carers or in an alternative setting for up to 6 weeks whilst their carer is away or takes a break.

This is known as an Annual Respite Allocation and is described in more detail in section 7 below.

6.3 In the event that the carer is requesting more than 6 weeks break from their caring responsibilities in a year, this request will be considered on a case-by-case basis at NEL ICB.

In cases when this is requested, the CHC Case Manager may also request a review of the care arrangements and whether the carer is still able to provide the level of care they have committed to as part of the care plan.

6.4 Care arrangements for the individual when their carer is taking planned respite can take various forms. This allows a wide range of options to be considered that meet both the individuals needs and their care preferences.

Whilst it will meet the assessed needs of the individual, it may not be possible to provide a direct replacement of the care being offered by the carer.

Respite care options include, but are not limited to:

- Care provided by another carer in the individual's network (e.g. extended member of the family or friend)
- A volunteer support coming into the home to deliver the care required
- Paid carer/s coming into the home to deliver the care required
- The individual doing daytime activities to provide a break for the carer, for example attend a day centre

- Overnight respite provision
- The individual spending a period of time in a supported living, residential or nursing care home.

6.5 Whilst every attempt will be made to provide some form of continuity of care, during the period when the carer is taking respite, it is possible that the existing range of services delivered into the home will be changed or suspended. For example, a domiciliary care package may be paused if the individual takes a temporary placement in a nursing home whist their carer is away on respite.

6.6 For those on Notional PHBs, where NEL ICB organises care for the individual, the carer will be required to provide the CHC Case Manager with at least two weeks' notice of the intended respite period in order to organise the care for the individual.

These respite hours will be recorded on the Respite Calculator and deducted from the remaining annual respite allocation.

6.7 There may be instances when the carer needs urgent or emergency respite and cannot give the required two weeks' notice. In such circumstances the carer should inform the CHC Case Manger as soon as possible so that NEL ICB can organise and pay a domiciliary care provider for the hours of care they provided during the emergency.

These respite hours will be recorded on the Respite Calculator retrospectively and deducted from the remaining annual respite allocation.

6.8 For those on a direct payment, the respite allocation will be included in their direct payment budget and the individual or their representative will need to organise the respite care arrangements for the individual while their carer is away.

Similarly, for those on third party PHB, the necessary care arrangements will need to be made via the third-party organisation.

6.9 There may be instances when the carer would like to go on holiday (within the UK or abroad) and would like the individual to accompany them. This would require paid carers who would provide all the assessed care needs during the holiday. This would allow both carer and individual to take a holiday.

In such cases a request must be made to NEL ICB at least three months before the planned holiday. Such requests will be considered by NEL ICB on a case-by-case basis following a full risk assessment regardless of whether the individual is in receipt of Notional Budget, Direct Payment or Third Party PHB.

7 Annual Respite Allocation and Annual Respite Allocation Calculator

7.1 Following the person-centred care planning discussion summarised in section 5 of this document, the CHC Case Manager will develop a weekly care plan for the individual which will identify the following:

- Their assessed care needs
- The care tasks to be completed
- When the care tasks are to be completed
- How long it takes to complete each task
- Who will complete each task (e.g. the individual themselves, paid carers, family or friend)
- The skillset of agency carer required to carry out each task if the care was commissioned from the AQP Framework for CHC Domiciliary Care.

7.2 This care plan will be used to commission domiciliary care agency staff from the AQP framework if they are needed to look after the individual at home.

The AQP Framework has a range of domiciliary care agencies that have been vetted by the NHS and employ carers with the necessary skills to meet the needs of CHC eligible individuals and have agreed hourly rates of pay with NEL ICB.

7.3 The care plan will specify any time of day or night the individual can be left on their own without care or supervision.

7.4 The care plan will highlight tasks that are completed by family or friends and how long these last. It will also highlight any time of the day or night when family are not providing an intervention but are “maintaining the safety” of the individual. This could be because the individual lacks capacity or needs supervision and unable to call for help.

7.5 Based on the care plan information, the Annual Respite Allocation Calculator will be completed for the individual which calculates the hours of care provided by carer each week, to meet the individual’s assessed needs and therefore, the hours of care NEL ICB would need to put in place if the carer took 6 weeks respite.

7.6 The Annual Respite Allocation Calculator also calculates the cost of this care if it was provided by a home care agency provider on the AQP Framework.

This cost is the Annual Respite Allocation for the individual and it is approved by NEL ICB at the beginning of the financial year or following the individuals CHC annual review.

7.7 The Annual Respite Calculator ensures that:

- the individual/ their representative have transparent information on the cost of their care if and when carer needs respite, and this is consistent with the principles of PHB and person-centred care.
- the individual and their carer can plan the respite the carer will need.

- NEL ICB can document and track the respite hours used by carer and pay care agencies appropriately.
- a review of care arrangements particularly where carers are needing/ requesting more than 6 weeks respite which may indicate that they are struggling to provide the level of care they have agreed to.
- equity in the respite offer for all individuals across NEL ICB.

7.8 The Annual Respite Allocation Calculator (see Appendix) is updated by NEL ICB annually in April or as soon as revised rates for providers on the AQP Framework is agreed.

7.9 The Annual Respite Allocation allows the individual and their carer to know exactly how much it would cost NEL ICB to commission care from an AQP home care agency when the carer takes respite.

It allows the carer flexibility around when they take respite as each episode of respite does not need further approvals by NEL ICB. This reduces delays for the carers who may have made some respite plan at short notice.

It also reduces the administrative burden for NEL ICB staff as they only need to approve respite funding once rather than repeatedly throughout the year and allows NEL ICB to forecast funds needed for all individuals if/ when their carers take a break during the course of the year.

7.10 The respite calculator also tracks the respite allocation used and the amount remaining for the rest of the year. Whilst the annual respite allocation is calculated based on domiciliary agency carers rates, the funds can be used to place the individual in nursing home or respite facility when their carer is away. This gives the individual and their carer greater flexibility, choice and control over their care arrangements.

7.11 An individual's annual respite allocation cannot be carried over from one year to the next.

7.12 The respite allocation can only be paid for care to meet the assessed needs of the individual as agreed in the care plan.

8 Transfer of care from NEL ICB to an LA and visa-versa

8.1 The LAs and NEL ICB have their own policies and procedures for determining the level of respite they provide to carers of individuals whether in receipt of adult social care packages or CHC.

8.2 There are currently no obligation on either organisation to replicate the respite offer provided by the other party.

8.3 When an individual moves from one organisation to another e.g. from being CHC eligibility to not eligible and visa versa, there is no obligation to replicate the respite offered previously and a new calculation will be made based on the current situation.

Appendix: Annual Respite Allocation Calculator 2022/23

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NHS
North East London

NHS North East London
Continuing Healthcare Dispute Resolution Policy and Protocol

FINAL DRAFT for publication

Contents

1 Aims and Values

1.1 The North East London Integrated Care Board (NHS NEL) has a vision to create a simpler more joined up health and social care system; one where the people of North East London have a consistently high-quality experience of Continuing healthcare (CHC) and do not see organisational boundaries. Instead, they experience CHC where they see familiar faces that are clearly connected to each other regardless of where people are seen; be that in hospital, the community or at home.

1.2 NHS NEL will achieve this vision by working collaboratively and in partnership with their local authority (LA) and health colleagues to ensure that they are providing the people of north east London with fair access to CHC which ensures better outcomes, better experiences, and better use of resources.

1.3 **The National Framework for NHS Continuing Healthcare and NHS funded-nursing care July 2022 (Revised)** (Paragraph 231) states that all Integrated Care Boards (ICBs) must cooperate with the other organisations within their footprint. ICBs are encouraged to establish joint working arrangements with these organisations which embed collaboration, to meet the health needs of the local population, including CHC. This includes collaborative working with relevant local authorities with statutory social care responsibility whose area falls wholly or partly within the area of the ICB (see also Practice Guidance 48).

1.4 In order to standardise the delivery of CHC and improve the quality of its delivery to its population, NHS NEL, with its partner organisations, have developed a single standard operating procedure (SOP) for CHC to ensure that all organisations and staff involved in the CHC process understand and agree to put the individual at the centre of the process and deliver CHC consistently and fairly.

The SOP has been designed to support NHS NEL, and its partners to ensure that all parties are.

- Following the guidance set out in the National Framework.

- Agreeing and following local protocols and/or processes which make clear how the NHS NEL (the local Integrated Care Board (ICB)) discharges its duty to consult with the LA (refer to paragraph 22) and how the LA fulfils its role as an important partner in the CHC process. (Refer to paragraphs 26-31).
- Developing a culture of genuine partnership working in all aspects of CHC.
- Ensuring that eligibility decisions are based on thorough, accurate and evidence-based assessments of the individuals' needs.
- always keeping the individual at the centre of the process and ensuring a person-centred approach to decision-making.
- always attempting to resolve inter-agency disagreements at an early and preferably informal stage.
- dealing with genuine disagreements between practitioners in a professional manner without drawing the individual concerned into the debate in order to gain support for one professional's position or the other.
- ensuring practitioners in health and social care receive high-quality joint training (i.e., health and social care) which gives consistent messages about the correct application of the National Framework.

1.5 The ICB will achieve this while ensuring that Individuals are never left without appropriate support while inter-agency disputes between statutory bodies about funding responsibilities are resolved.

National Framework (Paragraph 232)

1.6 It is intended that the SOP will support the delivery of CHC as 'business as usual' and therefore minimise the need to invoke any inter-agency dispute procedures. there may however be rare occasions where there may be a disagreement which cannot be resolved in this way.

1.7 This protocol sets out the principles and process by which NEL ICB will resolve any dispute which cannot be resolved through our inter-agency partnership relating to:

- eligibility of an individual for CHC
- joint funding arrangements
- operation of refunds guidance

1.8 This agreement is between NHS North East London and its LA partners, London Boroughs of Barking and Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest, and the City of London Corporation.

1.9 This policy does not apply to disputes between the NHS North East London and individuals or their representatives applying for CHC funding. These are dealt with through local resolution (See SOP) and the Individual's Requests for a Review of Eligibility process as outlined in paragraph 179-181 of the National Framework (Revised July 2022).

2 Relevant Legislation

2.1 The following legislation that is relevant to this policy and protocol is:

The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2020

https://www.legislation.gov.uk/uksi/2020/469/contents/made

The Care Act (2014)

https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

This policy will be reviewed whenever there is a legislative change that might affect its implementation or operation.

3 Relevant Policy

3.1 The following national policy that is relevant is:

National Framework for NHS Continuing Healthcare and NHS funded-nursing care July 2022 (Revised).
https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

This policy will be reviewed whenever there is a policy change that might affect its implementation or operation.

4 Introduction

4.1 The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2022) (National Framework) is a statutory document that sets out the principles, legal basis, policy, and statutory duties that Integrated Care Boards (ICBs) and Local Authorities (LAs) must follow in the administration and delivery of Continuing Healthcare (CHC).

4.2 The National Framework notes that disputes may arise between agencies and sets out the requirement that ICBs and LAs in each local area must agree a local disputes resolution process to resolve cases where there is a dispute between them about:

- A decision as to eligibility for CHC.
- Where an individual is not eligible for NHS Continuing Healthcare, the awarding of NHS-Funded Nursing Care (FNC), or the contribution of a ICB or LA to a joint package of care for that person.
- The operation of refunds guidance. (National Framework Annex E).

4.3 This process has been developed jointly between NEL ICB and the LAs, and demonstrates the commitment to work in partnership, and in a person-centred way, and to have a clear and agreed process in the event of a dispute arising between those agencies.

4.4 This policy relates only to disputes between the LAs and NHS NEL. Where an assessed individual, or a representative on behalf of an assessed individual, raises a disagreement on eligibility this is an Individual Review of Eligibility (IRE) and covered in the National Framework paragraph (212 – 227).

4.5 It is an important point to remember that a dispute may arise at the same time as an Individual Review of Eligibility (IRE) in respect of an eligibility decision – in such cases they should be managed concurrently with neither being delayed in order for the other to proceed.

4.6 The policy sets out the joint principles that underpins the process, alongside a number of operating elements and processes.

5 Roles of the NHS NEL and Local Authorities

5.1 The roles of the NHS NEL and the LA are clearly outlined in the National Framework in paragraphs 22 – 32.

5.2 The ICB has responsibility and accountability for CHC in several areas including:

- Ensuring delivery of, and compliance with, the National Framework for CHC.
- Ensuring that assessment mechanisms are in place for CHC across relevant care pathways, in partnership with the local authority as appropriate.
- The Standing Rules require ICBs to consult, so far as is reasonably practicable, with the relevant social services authority before making a decision on a person's eligibility for CHC (the Care and support statutory guidance should be used to identify the relevant social services authority).
- Making decisions on eligibility for CHC.
- Implementing and maintaining good practice.
- Ensuring that quality standards are met and sustained.
- Ensuring training and development opportunities are available for practitioners, in partnership with the local authority.

5.3 The LA role in relation to CHC includes: -

- Refer a person to NHS NEL when it appears that the person may be eligible for CHC.
- As far as reasonably practicable, provide advice and assistance when consulted by NHS NEL in relation to an assessment of eligibility for CHC – regardless of whether an assessment under the Care Act is required.
- When requested by the ICB, provide a person or persons to assist in a Multi Disciplinary Team (MDT).
- Respond within a reasonable time frame when consulted by the ICB prior to an eligibility decision being made.
- Respond within a reasonable timeframe to a request for information when the ICB has received a referral.

6 Inter-Agency Dispute Policy Joint Principles

6.1 This policy reflects the principles laid out in the National Framework, that are required to minimise the need to invoke a formal dispute resolution process. These are:

- Keep the needs of the individual at the heart of the process, ensuring a person-centred approach to decision making.
- NHS NEL and LAs will work together to minimise the need to invoke any formal dispute resolution and seek to resolve any disputes at an early, and preferably informal stage.
- NHS NEL and LAs must develop a genuine culture of partnership in relationship to CHC.
- All parties follow the guidance set out in the National Framework.
- Disagreement between practitioners is managed in a professional manner.
- Ensure that health and social care colleagues receive high quality joint training which gives consistent messages about the correct application of the framework.

- NHS NEL and the LAs have discharged their responsibilities in line with the requirements of the National Framework for the ICB duty to consult with the LA, and the LA's duty to co-operate (see above Roles of ICB and LA).

6.2 When a dispute exists, and the individual (or their legal representative) has asked for an IRE, the processes must run concurrently. There is no justification for delaying either process in favour of the other. Should a decision on eligibility be overturned in either process then this must be reflected in the other. NHS NEL will never hold separate positions on eligibility where there are concurrent IRE and Dispute processes.

7 Failure to Follow Policy

7.1 This policy is a joint policy and is based on genuine partnerships between NHS NEL and the LAs as outlined in paragraph 1.7.

7.2 Failure of an individual representing NHS NEL or the LA to follow this policy will be escalated in the first instance to their respective line manager.

7.3 Repeated failure by NHS NEL and or the LA to follow this policy will be escalated to the ICB Chief Nurse and the LA Corporate Director of Adult Social Care.

7.4 It is expected that the Executive will discuss with their counterpart to ensure appropriate actions are taken to ensure that the policy is followed, and support is given for individuals who fail to follow the policy.

7.5 Repeated failures may need to be managed in line with NHS NEL and LA workforce policies.

8 Legal obligations, rights, and duties

8.1 Nothing in this Agreement shall limit or constrain the legal obligations, rights or duties of either of the parties to Individuals or service users or as between themselves.

8.2 In the event that any dispute between the parties cannot be resolved using the procedures set out in this Agreement, the parties' legal rights shall not be affected, nor shall the parties be prevented from asserting those rights in any court of law or other forum.

9 Review

This policy will be reviewed whenever there is a legislative or organisational change that might affect its implementation or operation. In any event this policy will be reviewed annually.

Section 1

10 Managing disputes on CHC eligibility

10.1 It is expected that in the vast majority of cases, the MDT will agree on a recommendation of eligibility of CHC by undertaking a comprehensive multidisciplinary assessment. They will use all the available evidence of the individual's needs and apply professional judgment to make and support a recommendation of eligibility.

10.2 Not all disagreements between MDT members should be treated as grounds for invoking the inter-agency dispute resolution process. Under the current regulations (2022) and the National Framework, the MDT can account for contrasting views between MDT panel members and record these on the Decision Support Tool (DST).

10.3 The National Framework has clear guidance on the management of disagreements within an MDT noted within Practice Guidance 32 in that if practitioners are unable to reach agreements, then the higher score should be accepted, noted on the DST along with clear reasoned evidence to support it.

10.4 The ICB should accept the recommendation of the MDT unless there are exceptional circumstances.

10.5 Where NHS NEL is unable to accept or verify a recommendation by the MDT, the DST should be returned to the MDT to review with clear reasons why the ICB is unable to accept the decision based on para 10.4.

10.6 A dispute can only be raised once NHS NEL has made the eligibility decision and only on the following grounds*:* -

- Where the DST was not fully completed.
- Where there were significant gaps in the evidence provided.
- Where the MDT was not framework compliant.
- Where the lack of consultation with the LA resulted in the LA not being able to provide advice and support prior to a decision being made.

- Where there is an obvious mismatch between the evidence provided and the recommendation.
- where the recommendation would result in either authority acting unlawfully.

The acid test is, given the same evidence, would another MDT have made a different recommendation.

10.7 A dispute cannot be raised simply that the LA disagrees with an MDT recommendation.

The Dispute Process

The Inter-Agency Dispute Process is a three-stage process that aims to deliver a rapid conclusion where disputes occur.

11 Notification

11.1 To raise a dispute, the LA must complete the '*Dispute Proforma'* and send to the NHS NEL (CHC Head of Service) within 5 working days of the receipt of a formal outcome on eligibility. NHS NEL will have no obligation to accept a dispute raised after that time.

11.2 The dispute must be clear on the rationale for disputing the decision based on para 10.5 above.

11.3 The CHC Manager must acknowledge the dispute and arrange to discuss the case with the appropriate LA manager within *5* working days.

12 Informal

12.1 The CHC and LA managers, will each agree a representative to peer review the case. This peer review focuses on the process, the interpretation of the National Framework and whether the evidence seen by the MDT was sufficient to support the MDT recommendation. It is expected that this meeting will occur within 10 working days of the acknowledgment of a dispute. The outcome from this meeting is either that the original decision of NHS NEL is upheld. or that

the MDT is asked to reconsider the recommendation based on clear feedback from the CHC and LA manager.

12.2 If this meeting upholds the original decision of NHS NEL, then the dispute is closed and notification of this should be sent to the LA within 2 days of the meeting.

12.3 If there is significant and relevant information/evidence available and identified as part of the dispute as not having been included in the original assessment and recommendation process, it is essential that this is provided without delay. This should be sent to the CHC Manager and to the MDT who made the original recommendation so that they may consider that evidence. The MDT must meet with 5 days *of the receipt of the evidence*, to consider this evidence and make a recommendation.

12.4 If the recommendation of the MDT changes after considering the evidence, then the case must return through NHS NELs verification process and the dispute is closed. This does not prevent a further dispute being raised once the case has been verified by NHS NEL.

12.5 If their recommendation remains unchanged the MDT must inform the CHC Manager, who will record this on the *Dispute Resolution Form* and discuss the outcome with the LA to decide the next steps including escalation to formal stage if required.

12.6 Following informal discussions, the LA may choose to withdraw the Dispute. In such circumstances they should write to NHS NEL (CHC Manager) within 2 working days (by email) and advise that the dispute is closed.

12.7 A case may only go through the informal stage once to avoid getting stuck at this stage and not progressing.

12.8 Escalation to Formal Stage must be done within 5 days of the LA receiving an agreed decision from the informal stage.

Escalation must be made in writing, using the Dispute Resolution Form to NHS NEL (Head of CHC) stating the reason for the escalation. It must state why after the informal stage the dispute still exists.

13 Formal Stage

13.1 The formal stage requires senior managers (at a minimum of Head of Service level – to be agreed by NHS NEL/LA) to meet to consider the case.

13.2 The managers will meet within 5 working days of notification of escalation to formal stage and will address the dispute considering the following: -

- Whether the decision-making process was appropriately followed.
- The quality and quantity of the evidence supplied to the MDT and whether it was sufficient to support the decision made.
- Whether the evidence considered supports the identification of a Primary Health Need.
- Whether the recommendation was compliant with the National Framework.

13.3 It is not appropriate or permitted at formal stage to introduce new evidence or information. New information must be addressed at Informal Stage as there is a responsibility to allow the MDT to review any relevant and additional information.

13.4 The outcome of this meeting will be either that the original decision was upheld or overturned. This will be documented on the attached Dispute Resolution Form and signed by both managers.

13.5 Where the outcome is agreed, which may include that the original decision is upheld or overturned, this is considered agreed and binding on both the LA and the ICB as the final outcome on eligibility. This outcome will be recorded on the Dispute Resolution Form and actioned by both agencies accordingly. The Dispute is then closed.

13.6 Where the decision of the original MDT is overturned, this is recorded on the *Dispute Resolution Form.* This would then go through the NHS NEL verification process. The rationale for overturning the MDT's recommendation must be written up within 5 working days and fed back to the original MDT to ensure continuous learning.

13.7 In the event that the outcome of the meeting is not agreed the Dispute Resolution Form must clearly demonstrate the areas of outstanding disagreement and a clear rationale for the viewpoints of the respective agencies. The dispute is then automatically escalated to the Deferred Assessment Panel/External Review stage.

13.8 A case may only go through a formal stage once to avoid repeated reviews.

14 External Review Stage

14.1 It is expected that all disputes will be managed through the informal and formal routes. An external review is expected to be used rarely, if at all.

14.2 NHS NEL will arrange for a meeting to be convened with senior representation from the ICB and LA to jointly agree an external review from a neighbouring ICB or a CHC specialist consultant.

14.3 It expected that that this external review would occur within a minimum of 10 working days and maximum of 30 working days from the date of the decision to escalate.

14.4 NHS NEL and the LA will each independently produce an evidence bundle in relation to the case that focuses on the dispute. It must clearly state reasons why an agreement could not be reached at Informal and Formal stage. The Dispute Resolution Form should be used. The evidence used for this meeting should be the same evidence used at the formal stage. No new evidence can be submitted at this stage.

14.5 The evidence pack will be submitted to the external reviewer 5 working days prior to the meeting so that they will have sufficient opportunity to review the case prior to chairing the meeting.

14.6 The meeting will give an opportunity to both NHS NEL and the LA to present the case and for the external reviewer to ask any questions for clarification. The external reviewer role is in the first instance to facilitate an agreement - however when this is not possible, they will be required to give a decision.

14.7 The external reviewers' decision is considered final and both agencies will agree to abide by that outcome.

14.8 The external reviewer will provide a written report of their decision within 5 working days of the meeting. *The outcome of this review will be recorded on the Dispute Resolution Form.*

14.9 It is important to note that the view of the external reviewer does not impact in any way the right of the individual to request a IRE.

15 Governance and Reporting

15.1 NHS NEL and LA will monitor all cases through the disputes policy and will report regularly through existing governance arrangements on the number of cases where original decisions were either upheld or overturned and the rationale for this, to support continuous learning and improvement.

Section 2 Joint Package of Care

16 Contribution to Joint Packages of Care

16.1 The National Framework states that “If a person is not eligible for CHC, they may potentially receive a joint package of health and social care”. This is where an individual’s care or support package is funded by both the NHS NEL and the LA. This may apply where specific needs have been identified through the Decision Support Tool (DST) that are beyond the powers of the LA to provide services to meet these needs on its own. (See also sections 18-20 of the Care Act 2014)

16.2 The NHS NEL contribution to a care and support package may be through existing services such as Primary/Community services and specialist services, as well as through additional commissioned services.

16.3 NHS NEL and the LAs will develop a set of agreed principles and processes that ensure that decisions in relation to the contribution are open, transparent and consistent to effectively remove the requirement for using the dispute management process.

16.4 Until this is available the following process will be operational.

17 Formal Stage 1

17.1 Where NHS NEL and the LA meet and cannot agree the share of a joint package of care based on the Joint Care Package Protocols (**Currently being developed)** (or the principles laid out above) then this must be escalated as a dispute, in writing within 5 working days of the meeting.

17.2 The dispute is escalated to either NHS NEL in the case of the LA disputing the contribution or the LA in the case of the NHS NEL disputing. The disputer will copy the other party into the dispute.

17.3 Dispute will be escalated to a Senior manager (head of service level) who will, within 5 working days of the dispute, bring together ICB and LA representatives.

17.4 This meeting will review the evidence from both sides in relation to the contribution. They will consider as a minimum.

- The statutory responsibilities of the NHS and LA
- The care needs from the DST that are beyond the powers of the LA to meet on its own.
- Access to pre-existing services from the NHS (to ensure that this is an unmet need rather than non-accessed/non-commissioned service).
- Any other information.

17.5 It is important to remember that this meeting is not an MDT and therefore should not be discussing the merits of an eligibility decision previously made.

17.6 It is expected that this meeting will be able to manage the vast majority of disputes.

17.7 If this meeting cannot reach a decision, then this is immediately escalated to formal stage 2. The point for disagreement will be captured on the Inter-Agency Joint Care Package Dispute Form (to be developed).

18 Formal Stage 2

18.1 Where NHS NEL and LA have completed the informal stage and cannot agree the share of the joint package of care, based on the Joint Care Package Protocols (Currently being developed), (or the principles laid out above) then this must be escalated to formal stage, in writing within 10 working days of the meeting.

The senior managers involved in formal stage will present the case to the formal stage officers for resolution.

18.2 As this dispute is about the contribution to a joint package of care rather than the care package itself there is no requirement for further clinical or professional involvement.

18.3 It is beholden of the ICB Chief Nurse and the LA Corporate Director of Adult Social Care to make the final decision on the split. Their decision is binding on

both parties. Where nominated deputies are used the organisation must ensure that these deputies have the appropriate level of delegated authority to make financial decisions.

Section 3 Management of refunds

19 Management of refunds

19.1 A decision on eligibility remains in place until such time that NHS NEL revises that decision.

19.2 It is explicit in the framework that people in receipt of care cannot go without care during the dispute process.

19.3 The general principle is that whichever agency had been funding the care provision prior to the assessment and dispute process will continue to fund the care provision during the dispute process.

19.4 The National Framework set out three scenarios in relation to the management of care costs and refunds which are: -

A. Where there is a need for health or care and support to be provided to an individual during the period in which a decision on eligibility for CHC is awaited.
B. Where an ICB has unjustifiably taken longer than 28 calendar days to reach a decision on eligibility for CHC.
C. Where, as a result of a Local Authority or an individual disputing a CHC eligibility decision, the ICB has revised its decision.

A

Where there is a need for health or care and support to be provided to an individual during the period in which a decision on eligibility for CHC is awaited.

19.5 When a case is in dispute then the decision on eligibility is awaiting. In these cases, the agency which is paying for the care at the time will continue to fund the care until the outcome of the dispute is known.

19.6 At the point where a decision is made, the effective date of eligibility for CHC is either day 29 (from receipt of checklist) or the original MDT date – whichever is earlier.

19.7 Where this has resulted in the LA or the individual paying for care that they should not have been, NHS NEL agrees to reimburse any the care costs incurred as per above para.

19.8 Where the individual is to be reimbursed, NHS NEL will make an ex-gratia payment to the individual following the guidance set out within Managing Public Money[1] especially in relation to an individual who may have suffered hardship or injustice.

19.9 Where this has resulted in NHS NEL paying for care that should have been the responsibility of the LA then the LA agrees to reimburse care costs incurred.

19.10 Where this has resulted in the NHS NEL paying for care costs that are outside the responsibility of the LA (i.e., self-funders) NHS NEL will take no action to recover costs.

[1] https://www.gov.uk/government/publications/managing-public-money

B

Where an ICB has unjustifiably taken longer than 28 calendar days to reach a decision on eligibility for CHC.

19.11 The National Framework places a clear expectation on the ICB that in most cases, it should take no longer than 28 calendar days from the ICB being notified of the need for assessment of eligibility for CHC to making an eligibility decision.

19.12 When a ICB has taken longer than 28 days to make a decision and where an individual is eligible for CHC, it will refund directly to the individual or the LA, the costs of the services from day 29.

19.13 Where the individual is to be reimbursed, the ICB will make an ex-gratia payment to the individual as set out in the Managing Public Money[2] guidance especially in relation to an individual who may have suffered hardship or injustice.

19.14 The refund should be made unless the ICB can demonstrate that the delay is reasonable as it is due to circumstances beyond the ICB's control which include:

- Evidence (such as assessments or care records) essential for reaching a decision on eligibility has been requested from a third party and there has been delay in receiving the records from them.
- The individual or their representatives have been asked for essential information or evidence or for participation in the process and there has been a delay in receiving a response from them.
- There has been a delay in convening a multidisciplinary team due to the lack of availability of a non-ICB practitioner whose attendance is key to determining eligibility and it is not practicable for them to give their input by alternative means such as written communication or by telephone.

[2] https://www.gov.uk/government/publications/managing-public-money

C

Where, as a result of an individual disputing an CHC *eligibility decision, the ICB has revised its decision*.

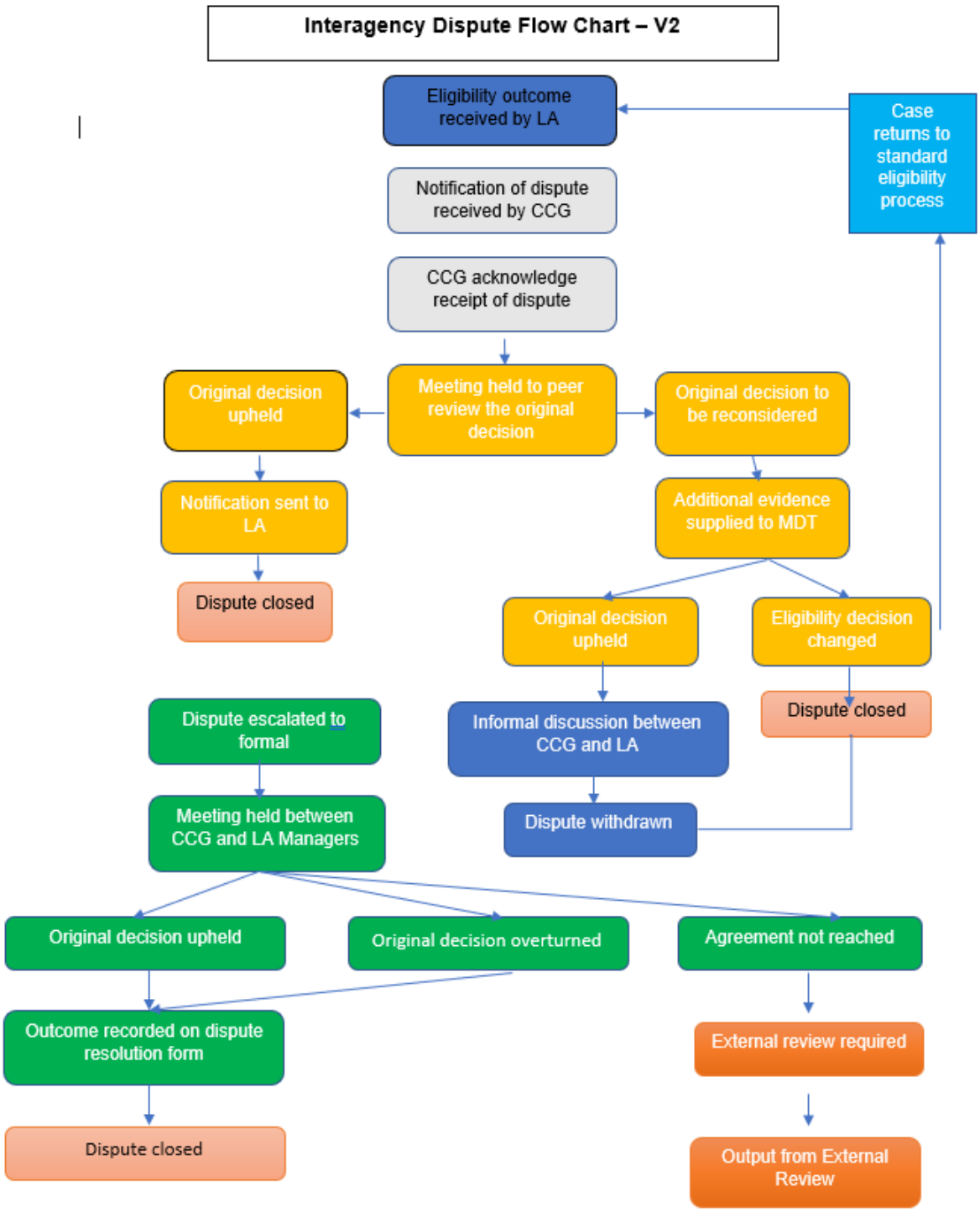
19.15 The process for the management of an individual review of eligibility is set out in NHS NEL's CHC Standard Operating Procedures as reflected in the National Framework

19.16 Where NHS NEL is required to reimburse the individual, this will be done via an ex-gratia payment to the individual following the guidance set out within Managing Public Money[3] especially in relation to an individual who may have suffered hardship or injustice.

19.17 Where this has resulted in the LA or the individual paying for care that they should not have been, the ICB agrees to reimburse any the care costs incurred as per 19.16 above.

[3] https://www.gov.uk/government/publications/managing-public-money

20 Appendix A - Inter-Agency Dispute Flow Chart



21 Appendix B - Inter-Agency Dispute Time Line

Inter-Agency Disputes Resolution Policy Time Line				
	Stage	**Policy paragraph**		**Time**
	Notification	11.1	Local Authority raises a dispute after formal notification of CCG eligibility decision	5 days
			CCG to acknowledge dispute	*2 days*
	Informal Stage	12.1	Peer review meeting	10 days
		12.2	*If peer review meeting upholds decision notice of outcome and closure of dispute*	*2 days*
		12.3	If peer review is asking MDT to review their decision to hold further MDT	5 Days
		12.6	*Once case has been back to MDT Local authority to decide to close case or escalate*	*2 Days*
	Formal Stage	12.8	Escalation to formal stage to be undertaken after agreed outcome from informal stage	5 days
		13.2	Managers meet either accept decision or overturn	5 days
		13.6	*If referred back to MDT managers write up rational for overturning decision*	*5 days*
	External Review	14.3	External Review meeting	10-30 days
		14.5	If still in dispute referral for external review and pack compiled	5 days
		14.8	External Reviewer report sent to CCG	5 days

22 Appendix C – Inter-Agency Dispute Form (Informal Stage)

Continuing Healthcare Inter-Agency Dispute Form (Informal Stage)			
Individual's Name			
Address			
NHS Number		CHC Reference Number	
Date of NHS NEL Decision letter		Date decision Letter received	
Please note: - Disputes must be received by NHS NEL within 5 working days of receipt of the decision letter by the Local Authority. The date of receipt will be classed as two working days after the date of the decision letter.			

Reason for the Dispute (please select the one that applies)	
The ICB has failed to follow proper procedure and/or that the decision was not compliant with the National Framework. (i.e., The *DST is not fully completed, The MDT was not properly constituted, there was a failure by the CCG to consult with the LA, where the recommendation would result in either authority acting unlawfully)*	☐
The ICB reached a decision that, given the same evidence, another MDT would have made a different recommendation. (i.e., *Where there are significant gaps in the evidence to support the recommendation, where there is an obvious mismatch between the evidence provided and the recommendation.)*	☐

Rationale for Dispute
The following are the details as to why we are raising this dispute providing a clear rationale based on the areas identified above.

Authorisation by the Local Authority			
Name of Local Authority			
Officers Name		Job Title	
Phone		Email	

For ICB Use:				
Date Request Received				
Is the dispute accepted	Yes	☐	No	☐
An informal discussion has been set with the LA rep for:	Date		Time	

Outcome of Informal Discussion	
Agreed that the original CHC eligibility decision was correct	☐
Agreed to refer to MDT for a review of recommendation	☐
If referred back to the MDT what are the areas for them to review or consider?	

Was an agreement reached to resolve the dispute?	Yes	☐	No	☐
Proceed to formal stage.	Yes	☐	No	☐

Reasons for not being able to resolve the issues at informal stage.

Date Referred to Formal Dispute	
It should be noted that failure to successfully resolve dispute at the informal stage is monitored at Executive level of both CCG and Local Authority.	

Signatures					
NHS NEL					
Name:		Signature:		Date:	
Local Authority					
Name:		Signature:		Date:	

23 Appendix D – Inter-Agency Dispute Outcomes Form (Informal Stage)

Continuing Healthcare Inter-Agency Dispute Outcomes Form (Informal Stage)			
Individual's Name			
Address			
NHS Number		CHC Reference Number	
Following the informal review discussion of this case held on the (date) By NHS NEL and (LA)			
Outcome of Discussion (please select the one that applies)			
The reviewers agreed the eligibility Decision and the case was closed.			☐
The reviewers agreed to refer back to MDT			☐
Reasons referred back to MDT			
No agreement was reached so will proceed to formal stage			☐
Reasons for not being able to resolve issues at informal stage			
Rationale for Dispute			
The following are the details as to why we are raising this dispute providing a clear rationale based on the areas identified above.			
Signatures			
NHS NEL			
Name:		Signature:	Date:
Local Authority			
Name:		Signature:	Date:

24 Appendix E – Inter-Agency Dispute Form (Formal Stage)

Continuing Healthcare Inter-Agency Dispute Form (Formal Stage)			
Individual's Name			
Address			
NHS Number		CHC Reference Number	
Date of NHS NEL Decision letter		Date decision Letter received	
Please note: - Request for formal disputes must be received by the CCG within 5 working days of receipt of the **Notice of the outcome of Informal disputes** by the Local Authority. The date of receipt will be classed as two working days after the date of the notice.			
Reason for the Dispute (please select the one that applies)			
The ICB has failed to follow proper procedure and/or that the decision was not compliant with the National Framework. (i.e., The *DST is not fully completed, The MDT was not properly constituted, there was a failure by the CCG to consult with the LA, where the recommendation would result in either authority acting unlawfully)*			☐
The ICB reached a decision that, given the same evidence, another MDT would have made a different recommendation. (i.e., *Where there are significant gaps in the evidence to support the recommendation, where there is an obvious mismatch between the evidence provided and the recommendation.)*			☐
Rationale for Dispute			
The following are the details as to why we are raising this dispute providing a clear rationale based on the areas identified above.			
Authorisation by the Local Authority			
Name of Local Authority			
Officers Name		Job Title	
Phone		Email	

For ICB Use:				
Date Request Received				
Is the dispute accepted	Yes	☐	No	☐
An informal discussion has been set with the LA rep for:	Date		Time	

Outcome of Informal Discussion				
Agreed that the original CHC eligibility decision was correct and upheld				☐
Agreed that the original CHC eligibility decision is overturned				☐
Reason for the outcome decision				
Was an agreement reached to resolve the dispute?	Yes	☐	No	☐
Proceed to External Review.	Yes	☐	No	☐
Reasons for not being able to resolve the issues at formal stage.				
Date Referred to External Review				
It should be noted that failure to successfully resolve dispute at the informal stage is monitored at Executive level of both CCG and Local Authority.				

Signatures					
NHS NEL					
Name:		Signature:		Date:	
Local Authority					
Name:		Signature:		Date:	

25 Appendix F – Inter-agency Dispute Outcomes Form (Formal Stage)

Continuing Healthcare Inter-Agency Dispute Outcomes Form (Formal Stage)			
Individual's Name			
Address			
NHS Number		CHC Reference Number	
Following the informal review discussion of this case held on the (date) By NHS NEL and (LA)			
Outcome of Discussion (please select the one that applies)			
The reviewers agreed the eligibility decision and the case was closed.			☐
The reviewers did not agree and could not resolve the dispute			☐
Reasons for not being able to resolve the dispute at formal stage			
No agreement was reached so will proceed to External Review			☐
Reasons for referring to External Review			
Rationale for Dispute			
The following are the details as to why we are raising this dispute providing a clear rationale based on the areas identified above.			
Signatures			
NHS NEL			
Name:		Signature:	Date:
Local Authority			
Name:		Signature:	Date:

26 Appendix G – Inter-Agency Dispute Outcomes Form (External Review)

Continuing Healthcare Inter-Agency Dispute Outcomes Form (External Review)			
Individual's Name			
Address			
NHS Number		CHC Reference Number	
Independent Reviewers Decision			
ICB decision upheld			☐
ICB decision overturned			
Reasons for the decision			
Additional Comments and recommendations			
Reasons for referring to External Review			
Rationale for Dispute			
The following are the details as to why we are raising this dispute providing a clear rationale based on the areas identified above.			
Signature			
Reviewer Organisation			
Name:		Signature:	Date:

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NHS
North East London

NHS North East London and Partners
Continuing Healthcare Joint Care Package Arrangements and Funding Policy

FINAL DRAFT for publication

Table of Contents

1 Aims and Values

1.1 The North East London Integrated Care Board (NHS NEL) have a vision to create a simpler more joined up health and social care system; one where the people of North East London have a consistently high-quality experience of health and social care and do not see organisational boundaries. Instead, they experience a 'system' where they see familiar faces that are clearly connected to each other regardless of where people are seen; be that in hospital, the community or at home.

1.2 NHS NEL will achieve this vision by working collaboratively and in partnership with their local authorities (LAs) and other health colleagues to ensure that they are providing the people of North East London with fair access to joint packages of care which ensures better outcomes, better experiences, and better use of resources.

1.3 In order to standardise the delivery of services including joint packages of care, NHS NEL, with its partner organisations have developed a single standard operating procedure (SOP) for CHC which will include this policy. This is to ensure that all organisations and staff involved in the arrangements for joint packages of care and joint funding, understand and agree to follow this process and put the individual and their needs at the centre of the process and deliver care consistently and fairly.

2 Introduction

2.1 The joint funding process is advisory. Its purpose is to provide guidance on the arrangements for joint packages of care and joint funding to ensure that the approach is used consistently across the North East London area.

2.2 Individuals who will be considered for joint funding can come from a number of care pathways. One example is individuals who have already been considered for funding through The National Framework for NHS Continuing Healthcare & Funded Nursing Care July 2022 (National Framework).

2.3 The National Framework states that "If a person is not eligible for NHS CHC, they may potentially receive a joint package of health and social care". This is where an individual's care or support package is funded by both the NHS and the Local Authority (LA). This may apply where specific needs have been identified through the Decision Support Tool (DST) that are beyond the powers of the LA to provide services to meet these needs on its own. (See also sections 18-20 of the Care Act 2014)

2.4 The National Framework indicates that joint funding can be provided in any setting e.g.

- an individual in their own home or supported living where they have both health and social care needs.
- an individual in a care home (with nursing) who has nursing or other health needs, that are beyond the scope of the FNC contribution

- an individual in a care home (without nursing) who has some specific health needs requiring skilled intervention or support, that cannot be met by community nursing services and are beyond the power of the LA to meet.

3 Scope

3.1 The NHS NEL Joint Funding Policy applies to patients aged 18 or above or patients who are in the transition process where no alternative funding stream has been identified i.e., s117; s75 or s256 budgets; discharge to assess (D2A)

3.2 Those who have been through the CHC process. Health needs can be identified at 2 stages in the CHC process:

- If an individual has a negative checklist but has an identified health need which cannot be delivered by the LA then a referral can be made for joint funding.
- If a DST has been completed and the individual has been found not eligible for NHS CHC, the MDT should consider if the individual has health needs which are NHS NELs responsibility.

  In these cases, they can consider both FNC and joint funding as options to meet the identified health needs.

3.3 A joint package of care with the LA will only involve joint funding where there is an identified health need requiring an identified care intervention to be commissioned.

3.4 In these circumstances NHS NEL will fund the care costs for the identified health element of the package. This will be arranged through commissioned NHS funding or through the provision of NHS services such as district nursing, community physiotherapy etc.

3.5 Jointly coordinated NHS NEL and local authority reviews will be carried out for all joint packages of care.

3.6 The National Framework is clear that neither the LA nor ICB should “unilaterally withdraw from an existing funding arrangement” without consulting each other or the individual. Funding for a specific care provision will therefore continue through the existing statutory authority while a decision for joint funding is made.

3.7 In the rare occasion that a joint care package cannot be agreed between NHS NEL and the LAs the Dispute Resolution Policy and Protocol can be referred to.

4 Principles

4.1 NHS NEL and LA partners will agree who the lead organisation is in coordinating joint packages of care and ongoing reviews.
Lead coordination will normally be determined by the percentage of the split however individual organisations will have their own responsibilities within care planning, depending on complexities.

4.2 NHS North East London are responsible for the care planning for the health funded element of any joint package of care.

4.3 When the LA are the lead co-ordinators for joint funded packages of care NHS North East London will work collaboratively with them to broker and commission services, when necessary. This will be agreed by the Joint Care Package Panel on a case-by-case basis.

4.4 Clinicians will also support the LA by recommending appropriate care packages based on the assessment and care plans.

5 Process

5.1 Referral Criteria

5.1.1 Prior to consideration for a jointly funded package of care, including FNC, the following criteria must be met.

- The person must first have completed the CHC process and a final decision on eligibility made.
  - ✓ This could include a negative checklist where the individual has identified health needs. In these cases, a Nursing Needs Assessment /Joint Funding Request Form must be completed and sent to NHS NEL on confirmation of the negative checklist.
  - ✓ A non-eligible decision has been made and verified by NHS NEL.

or

- The person has identified health need that has not been addressed through the universal services outlined in 5.2

and

- The person is ordinarily resident or is registered as a patient with a General Practitioner within NHS North East London at the point the health need was identified.
- NHS North East London is the responsible commissioner.
- Or If the person is registered with a GP outside of the NHS North East London footprint, then the rules set out in the 'Who Pays? Determining which NHS commissioner is responsible for making payment to a provider' (June 2022) should be referred to for determination of responsible commissioner. (Paragraph 10.2)

5.1.2 The patient must have assessed health needs that are:

Above the contracted universal health service provision in North East London including, but is not limited to:

- ✓ primary healthcare.
- ✓ assessment involving doctors and registered nurses.
- ✓ rehabilitation/reablement and recovery (where this forms part of an overall package of NHS care, as distinct from intermediate care).
- ✓ respite healthcare.
- ✓ community health services.
- ✓ specialist support for healthcare needs.
- ✓ palliative care and end of life healthcare.

5.1.3 Above what the LA can provide as outlined in the Care Act 2014, i.e., needs are more than incidental or ancillary to the provision of service or facility above the nature of what the LA should be expected to provide.

5.2 Referrals

Referrals, where possible, should be made at key points by both NHS NEL and the LAs. e.g., post checklist, during an MDT discussion, following non eligible decision, post inter-agency dispute, post review of eligibility decision etc.

5.3 Joint Care Package Panel

5.3.1 If the above conditions are met a request will be submitted to NHS NEL by either the LA or NHS NEL using the Joint Care Package Request Form. (See Appendix 1).-

NHS NEL will coordinate the Joint Care Package Panel.

5.3.2 All joint care package requests will be considered by the Joint Care Package Panel which will have a representative from NHS NEL and the relevant LA.

5.3.3 The Joint Care Package Panel will meet at least monthly to discuss all cases that have been submitted.

5.3.4 The panel will complete the relevant sections of the Inter-Agency Joint Care package Request Form.

5.3.5 The clinical lead or care coordinator for the case will also be present while their case is being considered. This will enable NHS NEL and the LA staff to work together to discuss the individuals needs and come to an appropriate conclusion. It will also allow the health and social care panel members to ask any additional questions.

5.3.6 If the panel agrees that there are health needs which are more than incidental or ancillary to the provision of services or facility and above the nature of what the LA should be expected to provide, then they will complete the remaining sections of the Joint Funding Request Form.

5.3.7 The Joint Care Package Panel will agree the nature of the joint arrangements including if any universal services, telecare/telehealth or one-off services that health can provide that meet the individuals assessed health needs.

5.3.8 The Joint Care Package Panel will also agree if there is to be a financial contribution made by NHS NEL. They will use the care funding calculator to calculate the share as a percentage and a financial cost. This will be recorded on the Inter-Agency Joint Care package Request Form.

5.3.9 Once approval has been received to agree a joint package of care NHS NEL and the LA will agree who will be the lead coordinator/commissioner.

5.3.10 The lead organisation will have responsibility for case planning, management and setting the reviews.

5.4 Disagreements

5.4.1 If the Joint Funding Panel is not able to make a decision regarding the joint care package and funding arrangements then the case can be referred to NHS

NEL for consideration using the NHS NEL and Partners Dispute Resolution Policy and Protocol (section 11).

5.4.2 It is expected that disagreements will be rare and occasional, and it expected that all steps will be taken by the partnership to agree where a joint care package is appropriate and required.

5.4.3 The referral should be made to NHS NEL in writing within 5 days of the panel meeting and can be made by either the LA or NHS NEL.

5.5 Care Planning

5.5.1 An initial draft care plan will be drawn up by both organisations to agree the services that are required to meet the individual's needs. Each organisation will be familiar with the ICBs Choice and Equity Policy when considering the available options

5.5.2 Once the initial care plan has been agreed the lead organisation will take responsibility to work with the individual, their family and brokerage to put in place the appropriate services to meet their needs.

5.6 Ongoing Support and Case Management

5.6.1 NHS NEL and the LA will open a case on their digital system stating that the case is being jointly funded and who the lead organisation is for coordination.

5.6.2 Reviews will be undertaken on at least an annual basis, although some individuals will require more frequent review in line with MDT judgement and changing needs.

5.7 Contracting and Finances

5.7.1 Contracting, invoicing, and payments to the lead organisation will be made following the existing processes set at borough level.

6 Reviews

6.1 It is essential that all joint funded care packages are subject to scheduled reviews between NHS NEL and the LA, with the lead organisation maintaining the care co-ordination role.

6.2 The lead practitioner will lead on case management and is therefore responsible for coordinating the scheduled reviews and inviting their counterpart from the partner organisation. The initial review date will be agreed as part of the joint funding agreement and then scheduled on both internal digital systems.

6.3 Annual reviews should be completed by both NHS NEL and LA practitioners. There may be instances (e.g., less complex cases) where both parties may agree that the review can be carried out by the lead coordinator only on the basis that the other party will be consulted if issues arise that need to be discussed. The lead coordinator will also provide the other party with the review notes.

6.4 The joint funding agreement will be reviewed at the annual review or earlier if the person's needs have changed.

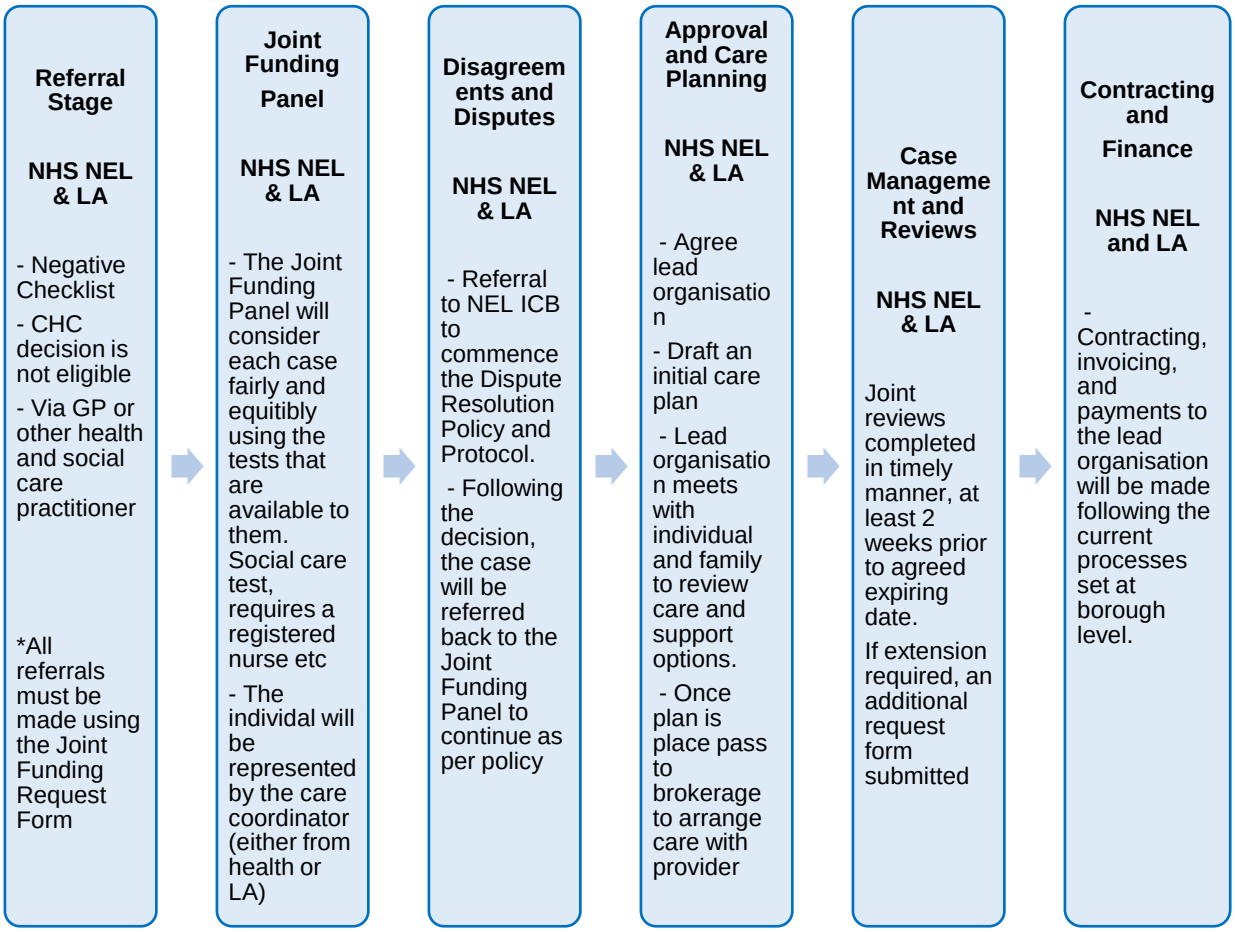
6.5 Where a component of care provision is time limited, the review will be coordinated at least 2 weeks prior to the end of the contract. This will allow the care provision to be extended or alternative arrangements made.

6.6 If an individual with an existing jointly funded support plan moves from their home into a Care Home or vice versa, it cannot be assumed that the joint funding arrangements will follow an individual. These cases will be sent to the Joint Care Packages Panel for review. The panel will be expected to make a decision on whether the joint care package arrangement will continue.

6.7 If a person with an existing joint care package moves out of borough, it cannot be assumed that the joint care package arrangements will follow the individual.

6.8 Consideration will be given to the Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers (June 2022).

7 Joint Funding Process



Appendix 1 - Inter-Agency Joint Care Package Request Form

Inter-Agency Joint Care Package Request Form (To be completed by either health or social care staff)						
Individual's Name:						
Address:						
NHS Number:		Date Request Made:				
Date of MDT:		Date of Outcome Decision:				
Is the individual currently receiving any health or social care services?			Yes	☐	No	☐
Please provide a brief description of services. (E.g., residential/domiciliary care/ community/district nursing)						
Does the individual have needs which are health related?			Yes	☐	No	☐
Please provide a brief summary and evidence of the care needs, input required, duration etc.						
Do you believe that these needs are more than incidental or ancillary to the provision of service or facility above the nature of what the LA should be expected to provide?			Yes	☐	No	☐
Please provide a brief explanation of why the needs should met jointly between NHS NEL and the LA						

Organisation(s) making joint care package request			
Name(s) organisation			
Officers Name		Job Title	
Phone		Email	
Name(s) organisation			

Officers Name		Job Title	
Phone		Email	

Joint Care Package Panel Decision

Date Request Received:	
Date Request Reviewed:	

Does the panel agree that there is evidence to support a joint care package between NHS NEL and the LA?	Yes	☐	No	☐

If the decision is **no**, please explain why this decision has been made.

If **yes** complete the **Joint Care Package Agreement.**

Joint Care Package Agreement

Name of local authority partner	

Step 1

Can the health needs be met through universal services?	Yes	☐	No	☐

Please explain the services to be provided and the needs that are being met.

Need	**Universal Service to be commissioned**
Details:	
Details:	
Details:	
Details:	

Step 2				
Can telehealth, telecare or equipment be used to meet any of the individual's needs?	Yes	☐	No	☐

Need	Telecare / Telehealth or Equipment
Details:	
Details:	
Details:	

Step 3				
Are there any 'one-off cost's to be used to meet any of the individual's needs? (i.e., Transport, Physio, OT.)	Yes	☐	No	☐

Need	Service or one-off cost
Details:	
Details:	

Step 4				
Does the individual's health needs require a financial contribution?	Yes	☐	No	☐

If yes, please use the care funding calculator to agree the percentage and the financial share.

Health		Social care	
Percentage:		Percentage:	
£:		£:	

Please specify what aspects of the care plan the contribution is for.
Details:

In no, please confirm that all health needs are met through services provided in steps 1-3.	Yes	☐	No	☐
Details:				

Joint Care Package Agreement

Was an agreement reached to agree joint care package?	Yes	☐	No	☐
If Yes provide details:				

Who is the lead organisation for care planning, management, and coordination?	NHS NEL	☐	Local Authority	☐

If **No** agreement was reached, please refer to **NHS NEL Inter-agency Disputes Policy**

Date referred to NHS NEL Inter-agency Disputes Policy	

Signatures

NHS NEL

Name:		Signature:		Date:	

Local Authority

Name:		Signature:		Date:	

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NHS
North East London

North East London Integrated Care Board
Continuing Healthcare Placement Policy

FINAL DRAFT for publication

Table of Contents

1 Aims and Values

1.1 The North East London Integrated Care Board (NEL ICB) have a vision to create a simpler more joined up health and social care system; one where the people of North East London have a consistently high-quality experience of Continuing Healthcare (CHC) and do not see organisational boundaries. Instead, they experience CHC where they see familiar faces that are clearly connected to each other regardless of where people are seen; be that in hospital, the community or at home.

1.2 The ICB will achieve this vision by working collaboratively and in partnership with their local authority (LA) and health colleagues to ensure that they are providing the people of north east London with fair access to CHC which ensures better outcomes, better experiences, and better use of resources.

1.3 The National Framework for NHS Continuing Healthcare and NHS Funded-Nursing Care July 2022 (Revised) (National Framework) (paragraph 231) states that all ICBs must cooperate with the other organisations within their footprint. ICBs are encouraged to establish joint working arrangements with these organisations which embed collaboration, to meet the health needs of the local population, including CHC. This includes collaborative working with relevant local authorities with statutory social care responsibility whose area falls wholly or partly within the area of the ICB (this is reinforced in the Practice Guidance 48).

1.4 In order to ensure good practice by putting the individual at the heart of the process NEL ICB, with its partner organisations have developed a single standard operating procedure (SOP) for CHC.

2 Introduction

2.1 This policy sets out the principles that NEL ICB will work to when commissioning individual packages of care for individuals eligible for NHS Continuing Healthcare (CHC) as determined by the National Framework

2.2 This policy will explain how NEL ICB and its LA Partners will commission care in accordance with the National Framework ensuring that equity and choice are central to the delivery of care.

2.3 This policy applies to all new individuals when they have been confirmed eligible for CHC. It will also include existing individuals where their care needs have changed significantly since their last review and require a different care package.

2.4 It does not apply to:

- Children under the age of 18.
- Individuals who are assessed as needing ‘fast-track’ CHC.
- Individuals subject to Section 117 aftercare under the Mental Health Act.

2.5 The policy has been developed to ensure that:

- NEL ICB maintain the ICBs vision on the delivery of CHC as set out in Section 1 - Aims and Values.
- A person-centred approach is taken by NEL ICB in making decisions about a care package and that the individual or their representative is at the centre of all discussions, ensuring that their care preferences and wishes are at the heart of the placement process.
- All CHC packages of care which are offered to an CHC eligible individual are sufficient to meet the individual's needs.
- Decisions about placements are made in a way that is fair, balancing NEL ICB's duties to the individual and to all the other patients for whom NEL ICB has financial responsibility.

3 National Policy Context

The strategic, legal, and operational responsibilities of this placements policy is set out in the following document's:

- The National Framework for NHS Continuing Healthcare & NHS Funded Nursing Care (July 2022)
- Care Act (2022).

4 Key Principles

4.1 Where an individual is eligible for CHC, NEL ICB has a duty to provide a package of care to meet the individual's assessed needs.

4.2 NEL ICB and their LA partners will work with the individual and/or their family/ representative/advocate to identify a range of potential locations and care options which are appropriate to meet the individual's assessed needs. NEL ICB will share and discuss the potential options with the individual and their representative.

4.3 In selecting a provider NEL ICB will firstly assess home care, care or nursing home providers that are on the Any Qualified Provider (AQP) Framework, which is the NEL ICB preferred provider list.

4.4 On the occasion that an AQP Framework provider cannot be found that meets the needs of an individual, an alternate provider will be sought.

4.5 When looking at the suitability of a care option, information that was recorded in the Decision Support Tool (DST) alongside the individuals and representative's care preferences and wishes will be considered.

4.6 For all placements, NEL ICB will need to satisfy itself that any packages of care that are to be commissioned for an individual will be provided by a provider who are:

- Able to provide an appropriate package of care which meets the needs of the individual through a skilled and trained workforce.
- Able to provide a safe and sustainable package of care.
- Offer value for money.

4.7 At all times NEL ICB will ensure:

- That the decision-making process for selecting the placement will always include the individual and their representative.
- The placement meets the individual's needs.
- Where they do not have capacity to make decisions about their care, NEL ICB will always act in the individuals' best interests.
- Where a deprivation of liberty may result in a care package NEL ICB will provide a Deprivation of Liberty Safeguards (DoLS) assessment and ensure that this is part of the commissioning agreement.
- That the process is robust, fair, consistent, and transparent.

5 Commissioning Arrangements

5.1 How we decide on the most appropriate type of accommodation.

- The CHC team will take the following factors and guidance from the National Framework into account when considering the type of care package. (An individual's home or a care or nursing home)

5.2 For those who wish to have care at home.

> *'Where an individual is eligible for NHS Continuing Healthcare and chooses to live in their own home, the ICB is financially responsible for meeting all assessed health and associated social care needs.*
>
> *This could include equipment provision (refer to Practice Guidance note 56), routine and incontinence laundry, daily domestic tasks such as food preparation, shopping, washing up, bed-making and support to access community facilities, etc. (including additional support needs for the individual whilst the carer has a break). However, the NHS is not responsible for funding rent, food, and normal utility bills. '*
> **(National Framework 315)**.

5.3 NEL ICB will consider the following factors when looking at a care package in the persons own home:

- The individual's views and those of their family or representative will be at the centre of the assessment and decision.

- Consideration of the individual remaining or returning to home.
- If an individual was in receipt of a care package from the LA is it appropriate to continue in this living situation and build the care package around them, avoiding a move to a new facility.
- Whether there be a significant impact in moving the individual?
- The extent to which care can be delivered safely at home and without undue risk to the person, the staff, or other members of the household (including children).
- The availability of contingency or replacement services if the care package at home breaks down.
- Is the current or new living situation close to family members who will have an active role in the individual's care.
- The cultural or linguistic needs of the individual.
- The suitability of accommodation.
- The individual's GP's ability to provide primary care medical support.
- The ability to provide the services within a best value context. I.e., the cost of care at home compared to a care home.

5.4 When a care home may be more appropriate than care at home.

There are a number of factors that NEL ICB will include when considering the type of accommodation that is most relevant for the individual.

There will be circumstances where an individual care needs would not be able to be delivered in their own home and a care home may be the most appropriate option.

These include:

- A care or nursing home may be more appropriate for people who have complex and high levels of need because they benefit from direct oversight by registered professionals and the 24-hour monitoring of people
- If there is the need for a registered nurse to directly provide supervision or care then the care would be expected to be provided within a care or nursing home.
- There may be specific conditions or interventions that it would not generally be appropriate to manage in a person's home. Eg. challenging and/or unpredictable behaviour.
- The need for waking night care may indicate a high level of support. It may also be difficult to provide waking night staff in the individual's home.
- If there is a preference for care at home then these would be carefully considered on a case-by-case basis and based on the availability of trained staff in the home care providers.

5.5 A detailed consideration and costing of the person's needs and how those needs can be met in different settings will be considered and a cost-benefit analysis will be conducted.

6 Capacity

6.1 If a person is assessed as lacking capacity, as defined in the Mental Capacity Act 2005, to decide about the location of their CHC package, the CHC team will commission the most cost effective and safest care available based on an assessment of the person's best interests. This will be carried out in consultation with the following:

- Any appointed advocate.
- Any attorney under a Lasting Power of Attorney, which does not authorise the attorney to decide by themselves as to where the person should live.
- A Court Appointed Deputy whose terms of appointment do not authorise them to decide by themselves as to where the person should live.
- Family members.
- Any other person who should be consulted under the terms of the Mental Capacity Act 2005 Code of Practice.

6.2 If there is a significant dispute between NEL ICB and the individual and their family/representative about where the person should live, NEL ICB will take advice about whether the matter is referred to the Court of Protection.

6.3 Alternatively, if the terms of a Lasting Power of Attorney or Deputyship grants authority for the Attorney or Deputy to make decisions about where an individual lives, NEL ICB will advise the Attorney or Deputy on what they consider to be the most appropriate placement. The Attorney or Deputy will then decide whether to accept that placement as being in the person's best interests.

6.4 Appropriate processes will be followed regarding a DoLS, which may be the result of a placement. The National Framework states what is required when a package of care or a placement will deprive someone of their liberty. (paragraph 344 and 345). This will be updated when the Liberty Protection Safeguards (LPS) process becomes live.

7 Funding CHC Placements

7.1 NEL ICB has a statutory duty to provide value for money when making decisions about commissioning services. NEL ICB must balance a range of factors including individual choice and preferences, quality, safety, and value for money.

7.2 Throughout the placement process, NEL ICB will recognise the need to achieve best value in its use of financial resources in order that it can share the finite NHS resources equitably across all individuals for whom it has commissioning responsibility.

7.3 NEL ICB will consider the services from a variety of care settings, which may include an individual's own home or a residential or nursing home. NEL ICB

has a duty to make a reasonable offer of care to the individual that will meet their assessed care needs.

7.4 NEL ICB will consider the comparative costs and value for money when determining the model of support to be provided to an individual.

They will not however set arbitrary limits on care packages based purely on the notional costs of caring for an individual in a home.

Such arbitrary limits are incompatible with the National Framework and personal health budgets which have been developed to enable people to live independently and work or participate in society. For more detail, please see below and Practice Guidance note 45. (National Framework 317).

7.5 Where more than one suitable care option is available (such as a residential or nursing home package and a home care package) the total cost of each package will be identified and assessed against the best outcomes for the individual.

While there is no set upper limit on the cost of care, each case will be considered on its own merits with the expectation being that the most cost-effective option that meets the individual's assessed needs will be commissioned.

7.6 NEL ICB will consider the views of the individual and their family or representative regarding the preferred placement and will ensure that the process is inclusive and transparent.

7.7 NEL ICB will make the final decision regarding the individual CHC care package.

7.8 NEL ICB recognises that some individuals who are eligible for CHC and who choose to live in their own home may be entitled to other services provided by the LA. This will be for the LA to address subject to the Care Act 2014.

These services include assistance and advice regarding property adaptation (refer to Practice Guidance note 56), support with essential parenting activities, deputyship or appointeeship services, safeguarding concerns, carer support or services required to enable the carer to maintain his/her caring responsibilities.

In these circumstances NEL ICB and its LA partners may have potentially overlapping powers and responsibilities. When this occurs NEL ICB and the LA will discuss these areas of needs and agree how these needs will be met on a case-by-case basis.

8 Exceptions

8.1 Where an individual has been assessed as needing a placement in a residential or nursing home, NEL ICB use the London-wide Any Qualified Provider (AQP) list. This is a list of providers who have met the commissioning requirements of NEL ICB.

8.2 The expectation is that all residential and nursing placements will have their needs met in one of these preferred provider homes.

8.3 However, some individuals who are eligible for CHC may have a complexity, intensity, frequency, and unpredictability in their needs which cannot be met by the providers on the AQP list.

8.4 In these situations, NEL ICB will consider, on a case-by-case basis, and in consultation with the individual and/or their families, the needs of the individual and commission the most appropriate care option available that provide the safe delivery of care.

The expectation is that when there is more than one option the placement that provides best value for money for NEL ICB will be the one that is commissioned.

8.5 An individual or their family / representative has the right to request that an individual's care is provided in a residential or nursing home that is not on NEL ICB's preferred provider list.

NEL ICB will consider all requests on a case-by-case basis and take into account the needs of the individual and the benefits this placement would have on them.

When these situations occur, NEL ICB will expect to review the provider to ensure it complies with its commissioning requirements and is able to meet the patient's assessed needs.

8.6 In some circumstances there may be no available placements on the preferred provider list that meets the individual's needs.

In these circumstances NEL ICB can offer a placement outside of the AQP list. When these situations occur NEL ICB will ensure that the preferred placement provides best value for money and is able to meet the needs of the individual.

9 Personal Health Budgets

9.1 NEL ICB can offer individuals the opportunity to have their own Personal Health Budget (PHB). A PHB is an amount of money to support someone's health and wellbeing needs, which is planned and agreed between the individual or their representative, and NEL ICB.

Individuals eligible for NHS CHC have the right to request a PHB if their care is to be provided in a community setting, including in their home.

Individuals placed in a care or nursing home will receive a PHB but this will be notional and be held within NEL ICB.

10 Paying for care and for additional private services

10.1 The principle that NHS services remain free at the point of delivery has not changed and remains the statutory position under the NHS Act 2006. This includes CHC packages of care.

10.2 Access to NHS services depends upon an individual's clinical need and not their ability to pay. NEL ICB will not charge a fee or require a co-payment from any NHS patient in relation to their assessed needs.

10.3 The NHS does not allow personal top-up payments to an NHS funded CHC package, where the additional payment relates to services assessed as meeting the needs of the individual and covered by the fee negotiated with the service provider.

10.4 The level of care for CHC care packages is determined by a comprehensive, multi-disciplinary assessment of an individual's health and social care needs. An individual or their family or representative cannot make a financial contribution to the cost of the care identified by NEL ICB when it is part pf the CHC assessment process, and the care package meets the individuals assessed care needs.

10.5 However, an individual has the right to decline NHS services and make their own private arrangements.

10.6 Where providers offer additional services which are unrelated to the individual's CHC assessed needs, the person may choose to pay for these additional services themselves. Examples of services that are likely to fall outside NHS provision include hairdressing, aromatherapy, beauty treatments and entertainment services.

If an individual wishes to pay for additional private, the individual will be advised by NEL ICB about the options available to voluntarily enter into a separate agreement with the care provider for the provision of the services.

If the patient enters into a voluntary agreement for the private provision of additional services, the provider will invoice the client separately for these.

If the provider refuses to invoice separately it could be considered unfair under Consumer Law and NEL ICB will not be able to purchase care at this home.

The Individual or their family or representative will be advised that they need to consider other homes, including those on NEL ICB preferred provider list.

10.7 In all cases the authorisation for the commissioning and funding of packages of care lies with NEL ICB. Packages of care which have not been authorised will not be paid for.

11 Reviews

11.1 The care package will be reviewed after the first three months of its commencement and then annually as a minimum thereafter to ensure that it continues to meet the person's needs.

The purpose of the review is not to reassess eligibility for CHC.

Where there is clear evidence of a change in needs to such an extent that it may impact on the individual's eligibility for NHS Continuing Healthcare, then the ICB will arrange a full reassessment of eligibility for NHS Continuing Healthcare

11.2 Where care is being provided at home, Individuals and their family or representative should be aware that there may be times where it is no longer appropriate to continue to provide care at home. This will be part of the review process for those having care at home.

For example, where deterioration in the person's condition may result in the need for clinical oversight and 24-hour monitoring that can only be provided in a care or nursing home. Or of the individual presents an increased risk that would prevent them from remaining at home.

11.3 If the review identifies that the individual's needs have changed to an extent that their care package may need a significant adjustment, the care package will be reviewed and all options will be explored.

This will not apply to increases in need or cost during a single period of up to two weeks that are required to cover either an acute episode of ill health or for end-of-life care to prevent a hospital admission

11.4 If the change in need requires a change to the location of care this will be discussed with the individual and their family or representative and the

principles set out in this policy will be followed, including the consideration of exceptional circumstances.

12 Disagreements and Disputes

12.1 If an individual, family member or representative disagrees with the package of care which has been offered and wishes to raise a complaint, they should make this in writing and submit any supporting evidence within 28 days of receiving the decision.

The process should follow the NEL ICB Complaints procedure.

12.2 When a dispute is received, it will be formally acknowledged by a letter that explains the dispute process and timescales.

12.3 Disputes will be heard by a panel consisting of clinicians and lay members of NEL ICB joint committee or relevant committees.

12.4 The Disputes Panel will only consider whether NEL ICB's offer was not reasonable considering all the circumstances including the individual's wishes and preferences.