NHS
North East London
Integrated Care Board

NHS North East London Integrated Care Board

28 September 2022, 1.30pm – 3.30pm – via MS Teams

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	1.30	Chair	Verbal	Note
1.1	Declaration of conflicts of interest			Attached	Note
1.2	Minutes of the meeting held on 1 July 2022			Attached	Approve
1.3	Matters arising			Attached	Note
1.4	Action log			Attached	Note
2.0	**Resident story**	1.35		Verbal	Discuss and note
3.0	**Chair and chief executive reports**				
3.1	Chair's report	1.55	MG	Attached	Note
3.2	Chief executive officer's report	2.00	ZE	Attached	Note
4.0	**Quality**				
4.1	System quality, safety and improvement report	2.05	DJ	Attached	Discuss
5.0	**Development of the Integrated Care Strategy**	2.15	ZE	Attached	Note
6.0	**NHS North East London approach to winter planning 2022/23**	2.25	ZE	Attached	Note
7.0	**Finance and performance overview**	2.35	HB	Attached	Note
8.0	**Governance**		CP		
8.1	Governance update and outcomes of July board development	2.45		Attached	Approve
8.2	Risk management update	2.55		Attached	Note
9.0	**Board forward plan**	3.05	Chair	Verbal	Discuss
10.0	**Questions from the public**	3.10	Chair	Verbal	Discuss
11.0	**Any other business and close**	3.25	Chair	Verbal	Discuss
Date of next meeting: 30 November 2022					

NHS
North East London
Integrated Care Board

North East London Integrated Care Board Register of Interests

Name	Position/Relationship with NEL ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Andrew Blake-Herbert	Chief Executive; London Borough of Havering	North East London Integrated Care Board	Financial Interest	London Borough of Havering	Employed as Chief Executive	01/05/2021		Declarations to be made at the beginning of meetings
Diane Herbert	Non-Executive Member	North East London Integrated Care Board	Financial Interest	Hertfordshire Partnership University NHS Foundation Trust	Non-Executive Director	01/07/2022		Declarations to be made at the beginning of meetings
Diane Jones	Chief Nursing Officer	North East London Integrated Care Board ICB Quality, Safety & Improvement Committee ICS Executive Committee	Non-Financial Professional Interest	Royal College of Nursing (RCN)	Professional membership	01/01/2020		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of Midwives (RCM)	Professional membership	01/01/1994		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Nursing & Midwifery Council (NMC)	Professional membership	01/01/1992		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Clinical Senate	Member	01/01/2017		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Homerton Hospital	Midwife (honorary contract)	01/01/2015		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Group B Strep Support (GBSS)	Director and Trustee	01/01/2020		Declarations to be made at the beginning of meetings
Dr Paul Francis Gilluley	Chief Medical Officer	North East London Integrated Care Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICS Executive Committee	Non-Financial Professional Interest	British Medical Association	I am a member of the organisation.	01/07/2022		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of Psychiatrists	Fellow of the College	01/07/2022		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Medical Defence Union	Member	01/07/2022		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	General Medical Council	Member	01/07/2022		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Stonewall	Member	01/07/2022		Declarations to be made at the beginning of meetings
Henry Black	Chief Finance & Performance Officer	North East London Integrated Care Board ICB Audit and Risk Committee ICB Finance, Performance & Investment Committee ICB Workforce & Remuneration Committee ICS Executive Committee	Indirect Interest	BHRUT	Wife is Assistant Director of Finance	01/01/2018		Declarations to be made at the beginning of meetings
			Indirect Interest	Tower Hamlets GP Care Group	Daughter is Social Prescriber	01/01/2020		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Clinical Commissioners	Board Member	01/01/2018	31/07/2021	Declarations to be made at the beginning of meetings
Jagan John	GP, Primary Care Partner Board Member	North East London Integrated Care Board	Financial Interest	Parkstone Holdings Ltd	Director	02/02/2020		Declarations to be made at the beginning of meetings
			Financial Interest	Aurora Medcare (previously known as King Edward Medical Group)	GP Partner	01/01/2020		Declarations to be made at the beginning of meetings
			Financial Interest	Parkview Medical Centre	GP Partner	01/05/2020		Declarations to be made at the beginning of meetings
			Financial Interest	Together First Limited (GP Federation)	Practice is a shareholder	01/01/2014		Declarations to be made at the beginning of meetings
			Financial Interest	Harley Fitzrovia Health Limited	Director and Shareholder	01/01/2018		Declarations to be made at the beginning of meetings
			Financial Interest	Diagnostics 4u (previously Monifieth Ltd)	Director and Shareholder	01/10/2020		Declarations to be made at the beginning of meetings
			Indirect Interest	Aurora Medcare (previously known as King Edward Medical Group)	Other GPs are family members	01/01/2020		Declarations to be made at the beginning of meetings
			Indirect Interest	New West Primary Care Network	Brother / GP Partner is the Clinical Director	01/11/2020		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Personalised Care – Healthy London Partnerships and NHS England London Region	Clinical Lead	01/05/2017		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	North East London Foundation Trust – Barking and Dagenham Community Cardiology Service	GPWSI in Cardiology	01/08/2011		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barking and Dagenham Health and Wellbeing Board	Deputy Chair	01/01/2018	30/06/2022	Declarations to be made at the beginning of meetings
			Financial Interest	Buxton Medica	GP partner is director and practice is share holder	31/10/2021		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barking & Dagenham, Havering and Redbridge University Hospitals Trust	Associate Medical Director for Primary Care in BHRUT	01/09/2022		Declarations to be made at the beginning of meetings
Marie Gabriel	Chair	North East London Integrated Care Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICB Workforce & Remuneration Committee ICP Committee	Financial Interest	Norfolk & Suffolk NHS Trust	Chair of the Board. Financial interest on the basis of being a NED with NSFT This contract ends 31.12.21.	01.04.2022		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Foundation for Future London	Trustee	01.04.2020	25/08/2020	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	West Ham United Foundation Trust	Trustee	01.04.2020		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	East London Business Alliance	Trustee	01.04.2020		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Race and Health Observatory	Chair	23.07.2020		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Labour Party	Member	01.04.2020		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Confederation	Trustee - associated with role as RHO Chair	23.07.2020		Declarations to be made at the beginning of meetings
			Financial Interest	Local Government Association	Peer Review	16.12.2021		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	UKHSA	Associate NED	25/04/2022		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Institute of Public Policy Research (IPPR)	Commissioner on the IPPR Health and Prosperity Commission	13/03/2022		Declarations to be made at the beginning of meetings
Mark Rickets	GP, Primary Care Partner Board Member	North East London Integrated Care Board	Financial Interest	GP Confederation	Nightingale Practice is a Member	02/02/2022		Declarations to be made at the beginning of meetings
			Financial Interest	Homerton University Hospital NHS Foundation Trust	Non-executive Director	02/02/2022		Declarations to be made at the beginning of meetings
			Financial Interest	Nightingale Practice (CCG Member Practice)	Salaried GP	02/02/2022		Declarations to be made at the beginning of meetings
			Indirect Interest	Health Systems Innovation Lab, School Health and Social Care, London South Bank University	Wife is a Visiting Fellow	02/02/2022		Declarations to be made at the beginning of meetings
Paul Calaminus	ELFT Chief Executive, NHS Trust Partner Board Member	North East London Integrated Care Board City & Hackney ICB sub-committee City & Hackney Partnership Board	Non-Financial Professional Interest	East London NHS Foundation Trust	Chief Executive	30/04/2021		Declarations to be made at the beginning of meetings
			Indirect Interest	Department of Health	Partner is employed by Department of Health	30/04/2021		Declarations to be made at the beginning of meetings
Philip Glanville	Local authority rep on ICB Board	North East London Integrated Care Board City & Hackney ICB Sub-committee City & Hackney Partnership Board ICB Finance, Performance & Investment Committee	Non-Financial Professional Interest	Growth Borough Partnership	Board Member	17/11/2021		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Greater London Authority (GLA)	Co-Chair of Green New Deal Expert Advisory Panel	01/03/2021		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Councils	Member of London Councils Ltd and London Councils Leaders' Committee	19/09/2016		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Councils	Digital Champion / LOTI Lead	01/10/2020		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	East London Foundation Trust	Resident Member	01/08/2019		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Unison	Union Member	01/11/2021		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Unite the Union	Member	01/05/2005		Declarations to be made at the beginning of meetings
Sue Evans	Associate Non-Executive Member and Interim Chair of the ICB Audit and Risk Committee	North East London Integrated Care Board ICB Audit and Risk Committee ICB Workforce & Remuneration Committee	Non-Financial Professional Interest	Worshipful Company of Glass Sellers' of London (City Livery Company) Charity Fund	Company Secretary / Clerk to the Trustees'	01/01/2014		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	North East London NHS	Self and family users of healthcare services in NEL	01/01/2017		Declarations to be made at the beginning of meetings
			Financial Interest	St Aubyn's School Charitable Trust	Trustee and Director of Company Ltd by Guarantee	01/01/2013		Declarations to be made at the beginning of meetings
Zina Etheridge	Chief Executive Officer	North East London Integrated Care Board ICB Audit and Risk Committee ICB Workforce & Remuneration Committee ICP Committee ICS Executive Committee	Indirect Interest	Royal Berkshire NHS Foundation Trust	Brother is employed as Head of Acute Medicine	17/03/2022		Declarations to be made at the beginning of meetings

Nil Interests Declared

Name	Position/Relationship with NEL ICB	Committees	Declared Interest
Caroline Rouse	Member of IC Board (VCS rep)	North East London Integrated Care Board	Nil
Charlotte Pomery	Chief Participation and Place Officer	North East London Integrated Care Board Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Havering ICB Sub-committee Havering Partnership Board	Nil
Francesca Okosi	Chief People and Culture Officer	North East London Integrated Care Board ICB Workforce & Remuneration Committee	Nil
Imelda Redmond	Non-Executive Member	North East London Integrated Care Board	Nil
Maureen Worby	Councillor in London Borough of Barking & Dagenham	North East London Integrated Care Board Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee	Nil
Shane DeGaris	Group Chief Executive, Barts Health, NHS Trust Partner Board Member	North East London Integrated Care Board	Nil

NHS
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Draft minutes – NHS North East London ICB board

1 July 2022 – 1.45pm – 2.30pm
Unex Tower, 4th Floor

Members:	
Marie Gabriel (MG)	Chair, NHS North East London and North East London Health and Care Partnership
Zina Etheridge (ZE)	Chief executive officer, NHS North East London
Paul Calaminus (PC)	NHS trust partner member
Shane DeGaris (SD)	NHS trust partner member
Diane Jones (DJ)	Chief nursing officer, NHS North East London
Henry Black (HB)	Chief finance and performance officer, NHS North East London
Paul Gilluley (PG)	Chief medical officer, NHS North East London
Dr Mark Ricketts (MR)	Primary care partner member
Diane Herbert (DH)	Non-executive member, NHS North East London
Rajiv Jaitly (RJ)	Non-executive member, NHS North East London
Attendees:	
Andrew Blake-Herbert (ABH)	Local authority executive participant
Charlotte Pomery (CP)	Chief participation and place officer, NHS North East London
Francesca Okosi (CO)	Chief people and culture officer, NHS North East London
Marie Price (MP)	Director of corporate affairs, NHS North East London
Anne-Marie Keliris (AMK)	Head of governance, NHS North East London
Anna McDonald (AMc)	Senior governance manager, NHS North East London
Apologies:	
Imelda Redmond (IR)	Non-executive member, NHS North East London
Dr Jagan John (JJ)	Primary care partner member

1.0	**Welcome, introductions and apologies**
	The Chair welcomed members to the first meeting of the ICB board and confirmed that the two local authority partner board members have been appointed and will be confirmed during the coming week. It was noted that ABH was in attendance to bring the perspective of local authorities across north east London. The voluntary sector board member is still to be appointed and the Chair confirmed that the ICB will continue to work closely with the voluntary sector to ensure their input. The Chair welcomed a number of people who had joined the meeting via MS Teams including staff members.
1.1	**Declaration of conflicts of interest**
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the ICB. No additional conflicts were declared.

	Declarations declared by members of the ICB are listed on the ICB's Register of Interests. The Register is available either via the Governance Team or on the ICB's website.
2.0	**Patient story**
	The Chair welcomed a service user, together with her husband and their British Sign Language (BSL) interpreter to the meeting to share their experience of using health, care and wider services in north east London. The key messages were: • There is a lack of understanding in all health and care service areas including GPs, dentists, mental health, hospital and education services regarding the difficulties faced on a daily basis by people who are profoundly deaf or hearing impaired. • There is a lack of understanding in regard to the different communication requirements that the patients and their families have and, therefore, what support they should be provided with. • Telephone consultations are inappropriate for anyone who is profoundly deaf or hearing impaired. • Mask wearing has added to the communication issues impacting on ability to lip read for example. • There are multiple issues regarding accessing BSL interpreters. GPs often rely on family members to provide translation, which brings issues of confidentiality and pressure on family members Bookings for interpreters are not always chased up. Final confirmation of booking is often not communicated to patient/family. This can result in appointments that cannot go ahead. As part of the discussion, the BSL interpreter explained that although basic BSL translation is helpful, for example for receptionists, anyone translating medical information must be a fully qualified interpreter and the patient should always be asked to confirm the level of interpretation they need i.e. full, lip reader, note taker. The Chair summed up the action needed: • Deaf awareness training needs to be provided for frontline staff. • Different successful models of interpreting services provided in other areas need to be explored. • The Chief Participation and Place Officer, Chief Medical Officer and Chief Nursing Officer to follow-up on the issues raised and present a progress report at the next board meeting in September. **ACTION: CP/PC/DJ.** The Chair thanked the service user, her husband and the BSL interpreter for sharing the daily challenges they face and apologised on behalf of the organisation and the wider system for the lack of access experienced. The Chair also thanked them for their willingness to work with us to improve access and assurance was given that the information shared will be used to enable the ICB to make the improvements that need to be made.
3.0	**Chair and chief executive reports**
	3.1 Chair's report The Chair presented her report and highlighted the following key areas: • The aims of the Integrated Care System • The four priorities that will be taken forward as a system and against which the Integrated Care Partnership will develop a strategy.

	• Feedback from the NHS Confederation conference. • Priorities for local people as advised by our eight Healthwatch leaders - this will be a regular feature in the report going forward to ensure our communities' views and priorities shape the board's agenda. • Feedback from the NHS trust non-executives networking group held on 10 June 2022. • Freedom to Speak Up - the Chair shared her pledge and confirmed that Diane Herbert is the ICB board's 'Freedom to Speak Up champion' and Diane Jones will be the executive lead. The ICB will continue to build on the successful achievements and learning from NEL CCG. The ICB board noted the report. **3.2 Chief executive's report** ZE began by thanking the former NEL CCG's governing body and staff for the strong foundations they have provided for the ICB. ZE also confirmed that the CCG's external auditor and legal advisers have verified that the transition from the former CCG to the ICB is in good order and the processes put in place for the new ICB follow NHS England's guidance and meet their expectations. The following key areas in the report were highlighted: • Our NHS institutions and partnerships. • Our voluntary sector. • Our workforce. • The people of north east London. • Leadership across north east London As part of the discussion, ZE drew particular attention to the need for the system to work together to address the high demand for urgent and same day care and urgent support for people in mental health crisis. Whilst this is placing additional pressure on health and care colleagues, there is also a focus on the high number of people who are still waiting a long time for planned hospital care as a result of the pandemic. ZE highlighted the joint work on the cost of living crisis which is also impacting on our workforce and residents and explained how we will continue to tackle the challenges together as a system. In regard to the close down of NEL CCG, HB explained the due diligence process that was undertaken to ensure the new ICB is fully aware of the legal duties passed from the CCG to the ICB in regard to obligations and liabilities. The due diligence work, led by the ICS programme and governance teams has been reviewed by internal auditors and legal advisers who have confirmed that the process has been comprehensive and thorough. Some of the documentation is live and is still being worked on such as the serious incident log and the CCG's closing balance sheet which becomes the opening balance sheet for the ICB. The balance sheet will be completed once the legacy CCG's accounts for the first quarter of 2022/23 are finalised which is expected to happen in the coming weeks. The due diligence report will be presented to the ICB's Audit & Risk Committee and progress advised to the ICB board. **ACTION: SE.** The ICB board noted the report.
4.0	**Strategy**
	4.1 Corporate objectives

	ZE presented the report and outlined the proposed approach which builds on the Integrated Care System's (ICS) purpose, priorities and principles as well as the four aims of an ICS. The first year, from now until April 2023, will focus on embedding the foundations for the achievement of our strategic and corporate objectives. The key points were highlighted: • Integrated Care Boards are completely new and as such, the proposed corporate objectives provide the foundations to achieve the aims of the ICB in the longer term. • The five-year strategy for the ICB will include a clear approach to the four priorities that bring the whole system together. • The finance strategy will support us to work as a system including through a three-year medium-term financial strategy with a focus on sustainability. • We will have a shared approach to population health with an approach to data and the digital infrastructure to support this and enable us to tackle inequalities. • We will have a system operating plan including elective recovery, mental health standards and a system approach to demand, particularly urgent and emergency care which ensures north east London residents get the care they need. • Our governance process will enable and support integration and focus our collective effort on our objectives. • As the board and system develops over the coming months, a full set of strategic objectives will be developed. • We will reshape the way we work to put our residents at the heart of services and strategies. • We will embed our clinical and professional leadership and focus on our workforce. Discussion points included: • The need to be a learning system and a learning organisation. • The need for a very clear plan for population health and tackling inequalities with a set of measures and outcomes. The ICB board: • Approved the corporate objectives for July 2022 to April 2023. **4.2 Working with people and communities' strategy** CP presented the strategy as a starting point as we continue to work together to identify our priorities for year one and build on existing relationships and trust. The strategy was submitted to NHS England in May 2022 and will be reviewed for best practice to share and will provide feedback and suggestions to each system. As an ICB and ICS we will be assessed later this year as part of the overall oversight framework on how well we are delivering on our participation objectives. More importantly, we will hold ourselves mutually accountable for the commitments we have made, and do that through this board and our wider integrated care partnership. The key points highlighted were: • North east London health and care partners are committed to working for and directly with residents, patients and communities and will put people participation at the heart of everything. • The strategy has been developed by colleagues across north east London

	including healthwatch, voluntary and community organisation leaders, patient and resident groups, participation and engagement staff. • The strategy is central to our agreed integrated care system purpose and we will work with and for all the people of north east London to create meaningful improvements in health, wellbeing and equity. • The good work that already exists within the system will be built on and participation and engagement leaders have been working together to capture the positive best practice to date. • The experiences shared at the start of the meeting highlight that there is a lot to do particularly in terms of accessibility and being inclusive and this is one of our first priorities within the strategy. • The strategy is a starting point and we will work together to identify our priorities for year one and we will be looking at the different ways in which we can make ourselves more accessible. Discussion points included: • Noting the work that still needs to be done in regard to our priorities and success measures. • The need to ensure workforce training improves the different ways in which we currently communicate, respond and listen. • How the strategy builds on the existing work of others and how this provides real opportunities to collectively capture the voice of our residents, patients and service users to particularly inform integration of care. The ICB board: • Approved the Working with People and Communities' strategy • Agreed that an update will be presented to the ICB board at its meeting in January 2023. **ACTION: CP**
5.0	**Governance**
	5.1 Governance and finance arrangements for ICB establishment ZE presented the paper and explained the need for the following key documents to be approved in order for the ICB to be able to operate safely and effectively: • NHS North East London ICB's Constitution • NHS North East London ICB's Governance Handbook containing: • Standing financial instructions (SFIs) which explain the rules for how the ICB uses its NHS budget and the permissions given to the board, committees and staff of the organisation in relation to this. • Scheme of Reservation and Delegation (SoRD) which sets out which board, committee and people can make decisions on core functions of the ICB. • High-level governance chart which summaries the functions and decisions. • Terms of reference for the committees and sub- committees which include the outline chairing and membership details. • Governance policies, including the Standards of Business Conduct and Conflicts of Interest Policy The main discussion points were: • The Constitution has been developed with the input of partner organisations over the past nine months and has been approved by NHS England. • The need to work very differently to how NHS bodies have previously.

	• The ICB board has a far wider range of people and organisations involved than any before it and this is replicated throughout our governance arrangements. • Health and care will only be improved by working together and through co-production with residents, carers, service users and patients in all of our work. • The governance handbook - is a supporting document which sets out how the ICB will operate and how decisions will be made. Further discussions across the system will be held in order to develop the contents of the handbook going forward. • A model set of Terms of Reference (ToR) is included in the handbook for the seven ICB sub-committees that are being established for each place. • The intention is to establish the key elements needed to run the new organisation. • There are new features in our governance including a real focus on our seven places with local decision making on health and care close to people with all the partners involved. • Provider collaboratives are building on what worked so well during the pandemic, focussing on reducing inequity and providing mutual support to benefit people across the whole of north east London. • Further guidance from NHS England on delegation is expected to be issued in the coming week which will inform how we further delegate responsibilities in line with the ICB's objectives. • The ToR will be considered by each committee as they begin to meet. • An updated version of the handbook will be presented to the board in November ahead of a more fundamental review for January 2023 as we prepare for April next year and further delegation, including other primary care services. **ACTION: CP** The Chair shared some of the feedback on the handbook that has already been received: • System purpose, participation and co-production need to feature throughout the ToR. • Clinical and professional leadership needs to be emphasised. • The aims of the ICS, the purpose and design principles and system working need to be more explicit in the ToR. • Further clarity on decision making is needed and on delegation. • The need to focus on our approach to governance and board conduct, which will be discussed at the board development event on 20 July 2022. As part of the discussion, HB confirmed that the Scheme of Reservation and Delegation will be amended in order to make authorisation limits, execution and authorising expenditure clearer. It was confirmed that amendments would be made to the ToR for the Quality, Safety and Improvement Committee so that the focus is on oversight and assurance and its relationship to the system-wide quality committee is clear. The Chair confirmed that both the Scheme of Delegaton and the quality, safety and improvement items will be on the agenda for the board development session on 20 July. **ACTION: HB/DJ/IR** The ICB board: • Adopted the constitution.

	• Agreed the draft governance handbook, noting that it will be further developed.
6.0	**Questions from the public**
	The Chair advised that questions from the public relating to future agenda items can be submitted in advance of the board meetings. However, as this was first meeting of the ICB board, the Chair invited members of the public who had joined via MS Teams to ask questions. There were no questions from the public. The process for asking question at the meetings can be found on the website.
7.0	**Any other business and close**
	There were no further items for discussion.
	Date of next meeting – 28 September 2022

Matters Arising

Matters Arising – item 2.0 on action log from last meeting

Introduction:

At the inaugural meeting of the NHS North East London Board, the resident story focussed on the issues experienced by a service user, her husband and the wider deaf community in north east London which were summarised by a local community advocate who supported the with British Sign Language (BSL) interpretation. In response, engagement staff have conducted a mapping exercise to establish a baseline in terms of access provision for local health and care services, along with the short/medium term plans for improvement. Chief Officers Paul Gilluley, Diane Jones and Charlotte Pomery met with the family and advocate on 31 September to hear more about their experience and wider issues impacting the deaf and hard of hearing community.

System next steps:

Following this, the next steps are as follows:

- Appropriate support is being provided to improve access for the family with relevant partners.
- A working group is being established to bring together partners, user-led organisations and people who are deaf or hard of hearing to build on best practice and co-produce solutions in line with the recommendations set out in the summary report that has been developed.
- A review of the British Sign Language (BSL) agencies that we have contracts with across north east London will be undertaken.

A further progress report will come to the Board in January 2023

Actions log

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
2.0 Resident story	**1 July 2022**	An update on progress made regarding the daily challenges faced by people who are profoundly deaf or hearing impaired when accessing health, care and wider services in north east London to be given at the next board meeting.	CP	Sept 2022	Covered under 1.3 – matters arising.
3.2 Chief executive's report	**1 July 2022**	Due diligence report on CCG closedown to be presented to the ICB's Audit and Risk Committee and progress advised to the ICB board.	SE	Sept 2022	Audit and Risk Committee chair to give verbal update.
4.2 Working with people and communities' strategy	**1 July 2022**	Update on the strategy to be presented to the ICB board at its meeting in January 2023.	CP	Jan 2023	On forward plan
5.1 Governance and finance arrangements for ICB establishment	**1 July 2022**	Updated version of the governance handbook to be presented to the board in November 2022 ahead of a more fundamental review for January 2023 (in time for April 2023).	CP	Nov 2022 / Jan 2023	On forward plan.
		Further work in regard to the Quality, Safety and Improvement Committee's terms of reference and the Scheme of Reservation and Delegation to be undertaken at the board development session on 20 July.	DJ/IR/ HB	July 2022	Completed and covered within the governance paper/will be incorporated in the updated Governance Handbook which will be provided in November 2022.

North East London
Integrated Care Board

NHS North East London ICB board

28 September 2022

Title of report	Chair's Report
Author	Marie Gabriel
Presented by	Marie Gabriel - Chair
Contact for further information	Marie Gabriel, Chair Marie.gabriel1@nhs.net
Executive summary	• Key issues: This paper sets out governance developments, the views of Healthwatch and Partner non-executives who are not on our Board and provides information on key national and local priorities to shape our thinking and forward agenda. • Recommendation: To note the report
Action required	Discussion
Previous reporting	The paper highlights where sections of its content have been discussed and informed elsewhere.
Next steps/ onward reporting	To use the content to inform the Board Assurance Framework and Quality approach of the ICB and to inform our forward agenda.
Conflicts of interest	No conflicts of interest
Strategic fit	The report relates to our strategic purpose of bringing partners together to improve outcomes, including mitigating risks to achieving our ambition.
Impact on local people, health inequalities and sustainability	The paper emphasises our commitment to equity and co-production with local residents, which will shape our culture and drive strategy.
Impact on finance, performance and quality	The partner discussions outlined in this paper will inform the system quality approach.
Risks	The partner discussions and the highlighting of the challenges faced by social care will inform the ICB strategic risk discussions.

1.0 Introduction

1.1 I begin the meeting acknowledging the sad passing of her Majesty the Queen Elizabeth II, sending our condolences to the Royal family and recognising the impact this has had, and will continue to have, on our residents and staff. Zina and I have formally written to

all ICB staff and our system partnership continues to address the impact on our population.

1.2 The remainder of this report informs the Board of the key points arising from NEL Non-Executive and Healthwatch meetings, to ensure their views are taken into account in Board decision making. It also informs the Board of the Chair and Non-Executive most significant activities, which will particularly inform the strategic direction of the Board.

1.3 The report specifically outlines the breadth of work underway through the Healthwatch Collaborative and the discussion of system risks and our quality approach undertaken by non-executive members and Trust Chairs. It also highlights the agreement of North East London Healthwatch Collaborative to send a participant observer to future Board meetings.

1.4 I take this opportunity to welcome Mayor Philip Glanville and Councillor Maureen Worby, Local Authority Constituency Members, Dr Jagan John, Primary Care Member, Caroline Rouse, Voluntary Sector Collaborative member and Sue Evans Interim ICB Audit Chair to their first Board meeting.

2.0 Chair's and NEM's Activities

2.1 The Board Non-Executive Members met along with our Associate Non-Executive members, who are assisting us through the first 18 months of transition, to confirm our committee membership. This was followed by conversations with Primary Care and local authority members to confirm their committee membership. Conversations are ongoing with Healthwatch and the Voluntary Sector Collaboratives on how best to ensure their Committee representation. The current Committee membership is attached at Appendix A. I take this opportunity to thank Rajiv Jaitly for his contributions as ICB Audit Chair and wish him every future success. My thanks to Sue Evans who has agreed to be ICB Audit Chair whilst we recruit a permanent replacement.

2.2 I have continued to meet regularly with Healthwatch and at our last meeting we continued our discussion about the need to ensure their effective and appropriate involvement in the governance of the ICB and ICS. This included Healthwatch support for development of the ICP Interim Integrated Care Strategy which is due in December and also our 5-year ICB Strategy which is due in the Spring. Whilst it is understood that Healthwatch would wish not to be a full member of the Board given their scrutiny role, North East London Healthwatches have agreed to nominate one of their members to be a participant observer. This would enable the voice of people and communities to be further enhanced within our ICB discussions through Healthwatch involvement in our Board conversations whilst not participating in the actual decisions made. The nominations process for their representative is ongoing and I will provide a verbal update at the Board.

2.3 The meeting also received feedback on a range of System projects that the Healthwatch Collaborative have been engaged in, including a Care Home Managers survey and conversations to understand their health and care support needs; work on access to and experience of primary care, including informing solutions for same day care; and working with communities to support our system maternity equity and equality work.

2.4 At our 15th September meeting the North East London ICS Trust Chairs and Non-Executive Members discussed our approach to quality and system risk in advance of

our Board discussion. The key points made are noted below and will helpfully inform our conversations as we move through our agenda.

System Approach to Quality

- The need to create a consistent approach to the gathering and understanding of quality data whilst not creating an additional burden of data gathering or duplicating what happens at provider Boards, local government Cabinets or within the voluntary sector
- A focus on the added value of System, with the need to focus on cross cutting quality issues and the joint identification of quality gaps and how to fill them
- The need for an understanding of the system risks to quality and their mitigation
- The impact of workforce challenges on quality, including an understanding that quality is enabled through front-line staff and the subsequent need, therefore for a clear understanding of the impact of workforce capacity and experience on our ability to meet our quality ambitions
- Whilst recognising the reasons behind the one-year approach to priority setting there is also a need to recognise that identifying areas for, and then securing quality improvement, will take longer
- The need to be clear on the conceptual model within our quality governance, clarifying what the role of the ICB is as opposed to role of provider collaboratives and place-based partnerships, including where and how we seek assurance, the addressing of joint challenges and enabling of improvement
- The need to focus on joint learning and to ensure our improvement is based on evidence and insight, for example the outcome of incident reviews and resident feedback
- The need for the ICB to be proactively open, sharing early indicators of challenges and expectations, underpinned by a genuine sharing of intelligence that all can access. This will also enable us to understand and learn from each other's challenges.

System Risks

- How to balance our statutory obligations at an organisational and system level without creating unnecessary complexity, duplication, information gathering requirements and use of executive time
- Balancing the budget so we are able to meet demand and national operational requirements whilst seeking to transform and integrate services and tackle health inequalities. This includes the mitigating risk presented by inflation to our budget and to our staff wellbeing, and also mitigating the costs of staff agency cover
- Workforce – ensuring that we have enough people, doing the right things in the right place and also that we are able to retain staff, improving their experience, health and wellbeing, and enabling their joint development
- Balancing the need to decentralise decision making to the front line with the need to achieve consensus across the system
- Having the resources to effectively address variation across the system
- Ensuring effective relationships with our people and communities so that they have the trust and confidence to access services as soon as is needed.
- Maintaining effective partnerships in a financially strained environment. ensuring that we are not NHS centric
- Ensuring a focus on North East London and its ambitions whilst addressing national and regional requirements.

2.5 The Integrated Care Partnership Steering Group met for the first time this month. Its first focus was on the Integrated Care Partnership Terms of Reference, and agreement of the Steering Group's own Terms of Reference. Importantly, the meeting considered the forward plan which will enable the production of the Interim Integrated Care Strategy by mid-December. My thanks to colleagues for their challenge and for their willingness to meet monthly so that we can meet the December deadline.

2.6 I attended the last NHS Confederation ICB Chairs Network which has a focus on social care. They key take away messages for me were that ICBs/ICSs needed to -

- Develop a deeper and broader understanding of social care work and how it contributes to effective and productive system working
- Have a commitment to diligently focus on workforce, with the development of a co-created workforce plan and a focus on joint training and support offers to retain staff. This would require us to accelerate workforce planning including sharing workforce data and removing levels of bureaucracy in recruitment, retention and development
- Have a commitment to shifting the way that resources are spent to maximise the benefit to the most vulnerable members of our population.

I have agreed with the Chief Executive that Social Care should be a focus at our next Board Development session.

2.7 London wide, as part of my membership of the London Mayors' London Health Board, I have accepted the invitation to the Mayor's Champion for Tackling Systemic Racism. This will, I am sure, inform our commitment to be an ICB defined by its proactive commitment to equity. Linked to this, through our membership of the national LGBQT+ Guiding Group, the Chief Medical Officer, Paul Gilluley, and I have begun early discussions on what a specific LGBTQ+ equity commitment could encompass for North East London.

2.8 My final highlight is my attendance at the Mental Health Summit, a meeting of service users, carers, voluntary organisations and partners to inform our Flagship Priority of mental health and the work of the Mental Health and Learning Disability Collaborative. As this meeting in on 21st September, I will share key highlights at the Board meeting.

3.0 Recommendation

3.1 The Board is asked to note this report.

Marie Gabriel – Chair
15.09.22

Appendix A

Committee	Membership
Workforce and remuneration committee NB: NEM remuneration committee which consists of partner members nominated by the Board will meet as required to approve NEM remuneration.	• Non-executive member - Marie Gabriel • Non-executive member – Diane Herbert • Associate non-executive member - Noah Curthoys, • Local authority partner member - Will Tuckley • Primary care partner member – Dr Mark Rickets • Vacancy
Audit & risk committee	• Interim non-executive member - Sue Evans • Non-executive member - Imelda Redmond • Associate non-executive member - Kash Pandya • Vacancy
Population health and integration committee	• Non-executive member – Marie Gabriel • Non-executive member – Imelda Redmond • Associate non-executive member – Fiona Smith • Associate non-executive member – Noah Curthoys • Local authority partner member – Cllr Maureen Worby • Primary care partner member – Dr Jagan John • Chief Executive - Zina Etheridge • Chief participation and place officer - Charlotte Pomery • Chief strategy and transformation officer - Johanna Moss (Oct 22) • Chief medical officer - Paul Gilluley
Quality, safety and improvement committee	• Non-executive member - Marie Gabriel • Non-executive member - Imelda Redmond • Non-executive member - Diane Herbert • Associate non-executive member - Fiona Smith • Local authority partner member - Cllr Maureen Worby • Primary care partner member - Dr Jagan John • Chief nursing officer - Diane Jones • Chief medical officer - Paul Gilluley • Chief participation and place officer - Charlotte Pomery
Finance, performance and investment committee	• Associate non-executive member – Kash Pandya • Associate non-executive member – Fiona Smith • Non-executive member – Marie Gabriel • Local authority partner member – Mayor Philip Glanville • Primary care partner member – Dr Mark Rickets • Chief finance and performance officer – Henry Black

North East London
Integrated Care Board

NHS North East London ICB board

28 September 2022

Title of report	Chief Executive Officer's Report
Author	Zina Etheridge, Chief Executive Officer
Presented by	Zina Etheridge, Chief Executive Officer
Contact for further information	Laura Anstey l.anstey@nhs.net
Executive summary	The following report provides an update on our continued development of NHS North East London and in particular our seven place-based partnerships and provider collaboratives.
Action required	To note.
Previous reporting	N/A
Next steps/ onward reporting	N/A
Conflicts of interest	N/A
Strategic fit	The report relates to the chief executive's intentions for the ICB and ICS and aligns to our strategic purpose, priorities and objectives.
Impact on local people, health inequalities and sustainability	The ICB will enable us to have greater impact as we are enabled to work in a more integrated way across health and care organisations in north east London.
Impact on finance, performance and quality	N/A
Risks	N/A

1.0 Introduction

1.1 Since the first meeting of the board we have been working through the summer to further refine and embed the new ways of working as an Integrated Care Board and prepare for the challenges ahead as we move in to autumn and winter. I have also continued to visit partners across the system, meeting staff and residents and seeing first-hand how we are running our health and care services. The following report provides an update on our continued development of NHS North East London and in particular our seven place-based partnerships and provider collaboratives. I also outline some highlights from my recent visits showcasing examples of good practice across the patch and look ahead to the challenges we face over the coming months.

2.0 The development of the NHS North East London Integrated Care Board

2,1 **Place based partnerships** – these continue to evolve and take shape with the focus on ensuring the right leadership is in place to support their vision and priorities. Accountable leaders at each place are responsible for providing overall executive leadership, enabling and challenging partners to combine their expertise and resources to drive meaningful improvements to health, wellbeing, and equity. Following a nomination process, the place partnership leads have now all been agreed by each partnership and are listed below. We are grateful to these colleagues for stepping forward into these roles and accepting the significant responsibility that this brings.

Place	Place partnership lead	
Barking and Dagenham	Fiona Taylor	CEO, London Borough of Barking and Dagenham
City and Hackney	Louise Ashley *(from Oct 2022)*	CEO, Homerton
Havering	Andrew Blake-Herbert	CEO, London Borough of Havering
Newham	Colin Ansell	Acting CEO, London Borough of Newham
Redbridge	Adrian Loades	Corporate Director of People, London Borough of Newham
Tower Hamlets	Will Tuckley	CEO, London Borough of Tower Hamlets
Waltham Forest	Ralph Coulbeck and Heather Flinders	CEO, Whipps Cross Hospital and Strategic Director of Families, London Borough of Waltham Forest

2.2 More broadly as our place based partnerships take shape, there is real enthusiasm and appetite for change from all partners and a real desire to harness the opportunities at place; for example engaging in depth on linkages with adult social care and the VCSE. Development sessions have been delivered out of which we are shaping a longer term and place specific development programme and the governance for how these partnerships are run is taking shape. Inaugural meetings of ICB sub-committees have happened in some places and all are scheduled over the next few weeks.

Local estates forums for each place have been established to ensure multi-agency capital and property related programmes are linked effectively to each Place.

There has been engagement on design of an operating model at each place and all partnerships are revisiting their priorities and outcomes to build an overall approach for the system.

In terms of delivery, immunisations are an increasing priority with place partnership forums being developed. At the heart of each partnership is the resident voice and participation options are being worked through to ensure this a key part of each partnership meeting.

2.3 **Provider Collaboratives** – our five provider collaboratives continue to take shape as follows:

2.4 Our **acute provider collaborative** is led jointly and equally by Barts Health, BHRUT, and Homerton Healthcare. It continues to develop its approach to support patients to receive the care that they need and reduce health inequalities. It is focused on building more efficient and more effective corporate and clinical support services, delivering transformation at scale, alleviating workforce pressures, and improving resilience and the development of staff and leadership talent.

The collaborative portfolio comprises eight programmes, five clinical and three strategic. These are: urgent and emergency care, planned care, cancer, critical care, maternity, acute clinical strategy, specialised services, and research and clinical trials.

Each programme is supported by a range of enablers. Each is at a different stage of development and maturity but all have a chair, agreed organisational host, and programme director. Most also have programme leads in place.

Overarching collaborative governance arrangements are in place and a procurement process is underway to identify a learning partner to advise the collaborative on how it can best build a sense of purpose and work together.

2.5 The **North East London Mental Health, Learning Disability & Autism Collaborative** builds on a strong track record of collaboration across north east London to improve outcomes for people with, or at risk of, learning disability and mental health problems.

It has an established set of priorities to deliver the NHS Long Term Plan for mental health and progress is being made against these. There is a particular focus at present on ensuring urgent and emergency care pathways for mental health are efficient and effective, and delivering on NHS Long Term Plan commitments for children and young people and improving access to psychological therapies and physical health checks for people with serious mental illness. The collaborative are developing new ways of sharing best practice and learning across North East London including clinical improvement networks.

National mental health priorities are expected to be extended to 2024/25 with the publication of the forthcoming NHS England strategic planning guidance. Mental health is one of the four key ICS priorities. There is a focus on developing expectations and priorities for mental health in reflection of the views and aspirations of service users, carers, residents, staff and partners. Over the next two months a process of engagement and participation is being undertaken, most notably through

a service user and carer led summit in late September, and through place-based engagement in October. The Collaborative will be testing the priorities for mental health with stakeholders in early November, with a view to this then constituting the mental health element of the ICS strategy in December.

The operating model for the collaborative is also under development. An ICB sub-committee for mental health, learning disability & autism is being established to meet for the first time in November 2022. This committee will carry a delegation for mental health from the ICB, and will over time, and subject to national delegation guidance, potentially develop into a Joint Committee.

2.6 **Primary care** - over the last 6 months we have been working with our key partners and clinical leaders to shape and establish the Primary Care Collaborative. This brings strategic primary care leadership together and will develop over the next year to include representation from all four primary care sectors including General Practice, Dentistry, Optometry and Community Pharmacy and will work at scale to agree the priorities that best support and improve primary care across North East London. Key programmes of work will include the delivery of the ICB strategy and the implementation of the Fuller review programme across North East London (NEL) and will involve close working across the whole system with partners in place based partnerships and provider collaboratives.

There are a number of principles that underpin the primary care collaborative including the agreement of a common approach and standards where needed, improving quality and reducing clinical variation across practices in the first instance. Our primary care clinical leads at place will support the primary care agenda within place-based partnerships to improve population health, reduce inequalities and develop linkages and act as the bridge to the collaborative to share best practice and build a consistent approach. The collaborative members and clinical leaders are committed to also working with other provider collaboratives to create accessible services that have been co-designed with our stakeholders and local residents with senior primary care clinicians providing leadership to reduce unwarranted variation and inequality in health outcomes, access to services and experience. The primary care team are developing the programme of work to facilitate and support the primary care collaborative and its membership as described.

2.7 The **community health collaborative** has been developing over the last 6 months in partnership with the ICB and provider Trusts in North East London - NELFT, ELFT, Barts Health, BHRUT and Homerton Healthcare. The community provider collaborative 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. The community health collaborative has developed the principles under which it will operate with the primary relationship being with place with a focus on the collaboration across community health providers focusing 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.

Development work in quarter 1 of 22/23 outlined the principles, initial work plan and strategic aims of the collaborative. The community health collaborative has taken on the responsibilities of the community based care programme in NEL and with partners, place and other provider collaboratives will further develop the governance and expanded work programmes over quarter 3 for implementation in quarter 4 of 22/23.

2.8 Following a successful bid last year to the NHS England national programme to support the development **of voluntary, community and social enterprise (VCSE) alliances** within integrated care systems, sector leaders locally have made good progress in setting the foundations in North East London.

Umbrella and infrastructure organisations have been working with their locally appointed consultant who has completed an extensive mapping exercise across the area to provide a full picture of what exists, services provided and gaps. There have been a series of events with the wider sector within boroughs and together to reach collective agreement on the approach within North East London, most recently in July this year.

Capacity remains an issue with VCSE leaders constrained in terms of competing pressures, but the leadership group is working well, with formally nominated members to the ICB board and ICP steering committee, initially on a 12 month interim basis.

Further discussions continue regarding terms of reference for the alliance, the leadership group and wider membership, along with further considerations on collaborative representation and borough gaps. The Alliance, with NHS NEL, have been successful in securing further funding to support infrastructure development at a borough level in the two places where there are gaps currently.

3.0 Integrated Care Partnership

A core focus of the partnership is the development of the Integrated Care strategy and we are also starting to plan work for the 5 year joint forward plan which will be a key piece in giving effect to the strategy. In addition, and as part of the overall strategy development we are planning a series of workshops in the autumn across the four partnership priorities – long term conditions, mental health, children and young people and employment – as well as a cross cutting one on the cost of living crisis, in the autumn to build into the strategy.

4.0 Winter

4.1 As we head in to winter our focus is on putting in place a robust system plan and structure that means we can navigate the challenges effectively as North East London. This will include a focus on the range of immunisation programmes we are required to deliver: polio, monkey pox, Covid-19 and flu. We know this will be an even more challenging winter than usual and I am working with partners across the system to ensure that we are working together to deliver services, provide mutual support and manage pressures collaboratively.

5.0 System partners

5.1 Congratulations to NELFT who have recently been rated as Good by the Care Quality Commission following a Well-Led Review earlier in the year. This reflects the improvements made since the previous inspection. Congratulations to Jacqui Van Rossum and team for this achievement.

6.0 Highlights from recent visits across North East London

6.1 Redbridge – in July I spent the day in Redbridge visiting a GP practice where we discussed their plans for prevention and addressing wider determinants of health. I also undertook a tour of Goodmayes hospital, witnessing the pressures we are seeing in our emergency departments. I met a range of clinicians and some patients

too. I also met the team at one of the Redbridge HASSs (the integrated health and adult social care teams) which was a great example of how we can make integration work. I also attended a round table with a range of primary care practitioners - hosted by Dr Anil Mehta to talk about the opportunities and challenges of the new system and concluded the day with a meeting with Redbridge CVS.

6.2 **King George's Hospital** - I was really privileged to spend a couple of hours at King George's Hospital recently, learning about the work that they are doing to improve productivity and patient experience. They are focusing on ensuring that waiting time is eliminated as much as possible so that patients can be seen and treated and get back to their normal lives as quickly as possible, and that clinicians time is used as productively as possible. It was also a real privilege to spend some time in operating theatres witnessing first-hand the fantastic and skilled work undertaken by our surgeons.

6.3 **Mile End Early Diagnostic Centre**. In July I met with colleagues at Mile End EDC. This opened to the public in 2021 and is dedicated to detecting disease early and boosting survival rates. During the visit I saw the incredibly intelligent design of the space and the way it works. This is testament to the way it was designed and developed and in particular three things; really strong clinical leadership, supported with great evidence on the most efficient ways of doing things; building staff into the design; and good co-production with residents.

In the EDC, the design minimises the amount of time people need to spend walking up and down corridors and working around each other in cramped spaces, saving clinical time, while booking and reception staff are in the same space so can cover for each other. The endoscopy washing rooms had sinks that can be raised and lowered so no one needs to spend long periods bent over them (no matter their height) and the reception desk has two levels including one that residents in wheelchairs can use. This smart approach to service design provides an important blueprint for other services and I was really impressed with the innovation and patient centred approach.

6.4 **London Ambulance Service**. I spent a day on a ride out with a team of paramedics and spent a short time with the call centre. It was really insightful to see the range of issues people contact 999 for. Many really needed a community response rather than the provision of an ambulance. As we head for a challenging winter, we will need to make sure these responses are available as widely as possible.

I would like to thank Daniel Elkeles and his team, but in particular the two crew members I spent the day with, for this really interesting day on the frontline of LAS's work.

7.0 NHS North East London staff roadshows

7.1 In July staff came together across two days to mark the launch of the new organisation and spend time reflecting on our four ICS priorities. It was fantastic to see so many people in person and to discuss how we can best build on our priorities around mental health, babies, children and young people, long term conditions and workforce. There was lots of energy and enthusiasm in the room and plenty of food for thought as we continue to develop NHS North East London and the wider Integrated Care System.

8.0 North East London CCG

8.1 The former North East London CCG has published the 2021/2022 annual report and accounts on the ICB website.

Zina Etheridge
September 2022

North East London
Integrated Care Board

NHS North East London ICB board

28 September 2022

Title of report	System quality, safety and improvement report
Author	Mark Gilbey-Cross, Director of Nursing Chetan Vyas, Director of Quality Development
Presented by	Diane Jones, Chief Nursing Officer
Contact for further information	Diane.jones11@nhs.net
Executive summary	This report is designed to provide the Board with an update on the development of a system quality framework, and to frame a discussion for the Board about how quality is being taken forward across the system.
Action required	• Consider and comment on the approach to creating a system wide framework • Consider and comment on the approach to place and collaboratives.
Previous reporting	N/A
Next steps/ onward reporting	Next steps as outlined within the report
Conflicts of interest	There are no conflicts of interest to manage in relation to the content of this report.
Strategic fit	The approach to quality is relevant to all the Board's strategic objectives.
Impact on local people, health inequalities and sustainability	The report outlines what this means for local people and how this will reduce health inequalities and any sustainability impact.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report.
Risks	There are no risks to the delivery as a result of this report.

1.0 Introduction

1.1 With the creation of Integrated Care Boards (ICB), the National Quality Board has set out a shared view of quality and good practice principles which underpin the work we do and outline what everybody has a right to expect when using health and care services. For service users this should be care that is: safe, effective, delivers a positive experience (caring, responsive and personalised), is well-led, sustainably resourced, and equitable.

2.0 Purpose of the report

2.1 This report is designed to provide the Board with an update on the development of a system quality framework, and to frame a discussion for the Board about how quality is being taken forward across the system.

2.2 The Board is asked to note the content of the report and agree the proposed next steps.

3.0 Background

3.1 Over the last few months we have been developing a system wide quality framework. The framework will support the ICS to achieve our ambitions which include meeting statutory obligations, sustainable quality improvements in health and care, and addressing inequality and inequity.

3.2 We are undertaking engagement with partners across the system to enable the ICS to develop a single view of quality to ensure 'high quality, personalised and equitable care for all, now and in the future'. In practice, this means that people deliver care that is:

Safe – delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers, supports and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur.

Effective – informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing wider determinants of health; delivered in a way that enables continuous improvements based on research, evidence, benchmarking and clinical audit.

Positive experience - responsive and personalised, shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable.

Caring – delivered with compassion, dignity and mutual respect.

Well-led – driven by collective and compassionate leadership, which champions a shared vision, values and learning; delivered by accountable organisations and systems with proportionate governance; drive by continual promotion of a just and inclusive culture, allowing organisations to learn rather than blame.

Sustainably resourced – focused on delivering optimum outcomes within financial envelopes, and a reduced impact on public health and the environment.

Quality care is also equitable – everybody should have access to high-quality care and outcomes, and those working in systems must be committed to understanding and reducing variation and inequalities.

3.3 The NEL ICS quality principles have been agreed as:

- Further develop an **open culture and learning system across the ICS** that enables improvement across a shared understanding of needs and issues.
- Take a **Quality Management System (QMS)** approach, defined in the Shared Commitment and add a fourth function around assurance across NEL.
- **Focus on an Improvement** culture that supports improving patient outcomes and reduces inequalities.
- Ensure a **clear line of sight** of quality measures, good practice, concerns, risks and mitigations from the point of care to system leaders.
- Have a **clear understanding of when to act on signals, respond together** in a timely and proactive way, and **address any gaps in intelligence**.
- Have a clear understanding of when to act on signals, respond together in a timely and proactive way, and address any gaps in intelligence.

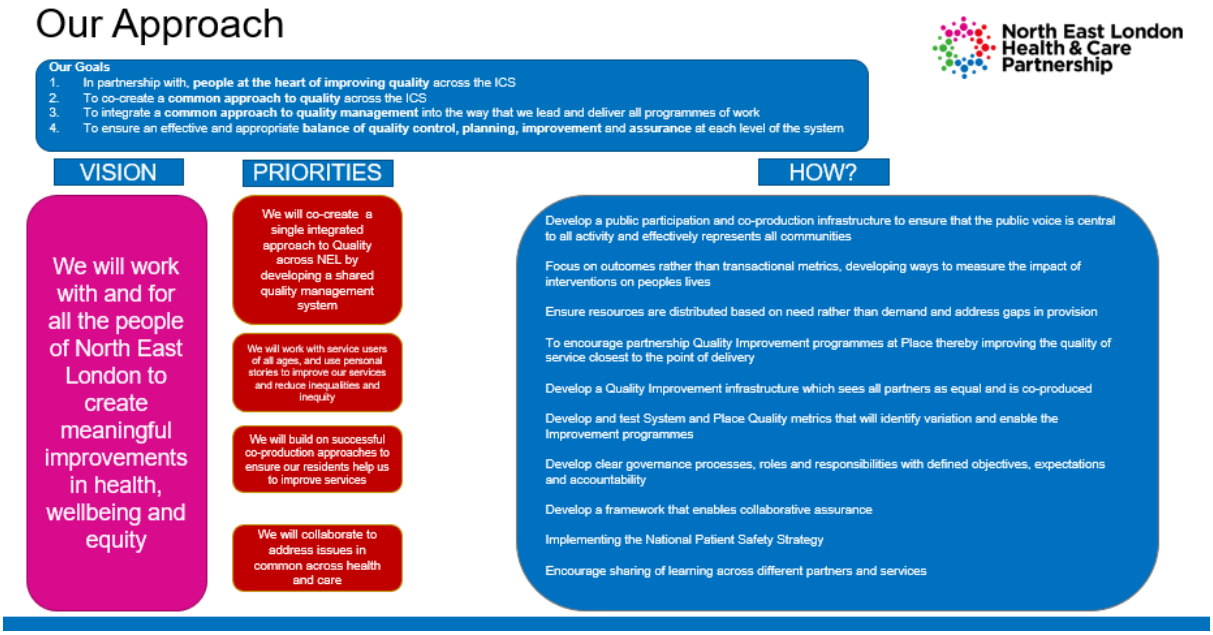
3.4 These principles align to the agreed quality goals:

1. In partnership with, **people at the heart of improving quality** across the ICS.
2. To co-create a **common approach to quality** across the ICS.
3. To integrate a **common approach to quality management** into the way that we lead and deliver all programmes of work.
4. To ensure an effective and appropriate **balance of quality control, planning, improvement** and **assurance** at each level of the system.

3.5 To date, development of the quality framework has identified four key elements:

1. Quality Planning
2. Quality Improvement
3. Quality Control
4. Quality Assurance

3.6 In combination these elements should create the culture, environment and system wide processes to deliver the vision for quality outlined earlier. The diagram below summarises the draft vision, priorities and key elements of the plan to deliver against those:



4.0 Governance

4.1 System quality is overseen by the NEL ICB Quality, Safety and Improvement Committee. The quality group works across the system and at place, enabling the improvement of quality across pathways of care and collaboratively undertake quality improvement programmes. The first meeting of this Committee is scheduled for October 2022.

4.2 The Committee is supported by the NEL System Quality Group.

NEL ICS System Quality Group – a strategic forum where partners can:

- **Triangulate intelligence, insight and learning** on quality matters across the system
- **Identify system quality concerns/ risks and opportunities for improvement and learning**, including addressing inequalities.
- **Develop system responses and actions to enable improvement**
- **Test new ideas**, sharing learning and celebrating best practice

5.0 Quality at Place

5.1 The way quality improvement will operate at Place, within a systems framework, is being developed through quality forums aligned to each place partnership supported by NHS North East London. Place partnerships are where the NHS, local authorities, and the voluntary and community sector integrate delivery, supporting seamless and joined up care and where we will most effectively tackle many health inequalities through prevention, early intervention, and community development, including at neighbourhood level. This model can generate rich insight into residents' views including of quality and help us to build a detailed understanding of where we need to focus our resources.

5.2 It is recognised that all partners, whether an NHS Trust, a Collaborative, a local authority or a wider stakeholder, already have established models of governance, accountabilities and relevant inspection frameworks for the delivery of quality for their organisation. In addition, partners bring dedicated resources, ways of working and relationships with users, communities and providers. Together, these elements allow us to build a joined-up quality approach which will identify and prioritise the key quality issues at place for local residents and for systems, and help to maximise the benefits of working at Place. To support this model, a draft concept Place Quality report, that includes a range of metrics aligned to the four ICS partnership priorities, has been developed and is being tested, shaped and revised by the Place Partnerships.

5.3 The aim of the system framework is to add value to the body of work already underway, to enable cross-cutting quality issues and trends to be identified and to ensure a wide range of perspectives is captured in our approach to quality improvement. The local model will build from residents' concerns about quality to ensure a joined-up approach that focuses on working together to improve resident experience and care.

6.0 The role of provider collaboratives in Quality

6.1 The provider collaboratives (Acute, Mental Health, Learning Disabilities and Autism and Community) which are each a collective of Trusts publish their organisation quality priorities through the quality accounts.

6.2 Quality priorities for provider Collaboratives (including the primary care collaborative) have yet to be developed, however it is envisaged they will align to the ICS quality priorities, given that provider Trusts have been able to align their respective organisational quality priorities as part of the co-production process. This approach enables the different parts of the ICS to see how their quality priorities fit with those of the ICS as a whole and enables us to demonstrate a system approach to quality and quality improvement.

7.0 Next Steps

- Further development of how Places will maintain quality oversight and drive local improvements.
- Temperature check on quality issues as viewed by social care colleagues.
- Development of a broad overview of quality and safety themes and issues with a focus on reducing unwanted variation and holding the system to account.
- Understanding of quality priorities for the next year at Place and by Collaboratives.
- Development of the Collaborative Assurance Framework within the overall System Quality Framework
- Development and testing of mechanisms to report from Place into the NEL ICS System Quality Framework and the NEL ICS Quality, Safety and Improvement Committee

8.0 Conclusion

8.1 Work continues to ensure NEL ICS has a robust approach to quality that has been developed in collaboration with system partners. This will ensure that is: safe, effective, delivers a positive experience (caring, responsive and personalised), is well-led, sustainably resourced, and equitable.

8.2 The Board is asked to:

- consider and comment on the approach to creating a system wide framework
- consider and comment on the approach to place and collaboratives.

Mark Gilbey-Cross, Director of Nursing
Chetan Vyas, Director of Quality Development
14 September 2022

North East London
Integrated Care Board

NHS North East London ICB board

28 September 2022

Title of report	Development of the Integrated Care Strategy
Author	Hilary Ross, Director of Strategic Development
Presented by	Zina Etheridge, Chief Executive Officer
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Executive summary	A new ICS Strategy Task and Finish Group is meeting fortnightly to support strategic work in the ICS. Improving population health and ensuring that the system meets the health and care needs of our population now and in future years are the central drivers to this work. There is also a key focus on tackling health inequalities. As part of its current work, the Task and Finish Group is supporting the new system requirements for ICSs. This includes developing the Integrated Care Partnership's Integrated Care Strategy due in December 2022 and the NHS Joint Forward Plan due before the end of the financial year. A series of workshops on the four ICS priorities and also one on our system response to the cost of living will take place in the Autumn to inform the strategy.
Action required	Note
Previous reporting	ICS Strategy Task and Finish Group ICS Executive Leadership Team Integrated Care Partnership Steering Group
Next steps/ onward reporting	Further updates will be provided over the course of the next few months including at the JHOSC and local partnership committees and boards. The workshops as set out in the attached pack will take place during October/November. The ICP steering group will discuss at their next meeting, including proposed final sign off process in advance of submission in December.
Conflicts of interest	N/A
Impact on local people, health inequalities and sustainability	Reducing health inequalities will be a central focus for the integrated care strategy.
Impact on finance, performance and quality	The strategy will set the direction for the system on financial sustainability, and improving access, experience and outcomes for our population.

Risks	There is a short timeline for the partnership to develop the integrated care strategy and there are competing pressures on resources. There is recognition within the guidance that strategies may be interim at this stage given timescales.

North East London Health & Care Partnership

Development of the integrated care strategy

Update on development of the North East London Integrated Care Strategy

Sep 2022

Hilary Ross, Director of Strategic Development

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Background

- In July our Integrated Care Partnership was formally established. This is a statutory committee that brings together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop an integrated care strategy for the area.
- System partners across the North East London Health and Care Partnership have already reached collective agreement on our ICS purpose and four priorities to focus on together as a system (see next slide). These priorities will be at the heart of our integrated care strategy in NEL.
- The first draft of the Integrated Care Strategy is due to be submitted in December 2022 and national guidance was published in August.
- The guidance states that the strategy should set the direction of the system across the area of the integrated care board and integrated care partnership, setting out how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life. It also highlights the opportunity to do things differently, including reaching beyond 'traditional' health and social care services to consider the wider determinants of health or joining-up health, social care and wider services.
- The integrated care strategy will form the backdrop to service developments led by the provider collaboratives, and a joined up approach on engagement will be key.
- The following slides outline our emerging principles for strategy work in NEL, national requirements and the strategy landscape more broadly as well as next steps for developing the strategy over the coming months.

Our partnership purpose and priorities

Our purpose

"We will work with and for all the people of North East London to create meaningful improvements in health, wellbeing and equity."

Our approach

- Improve quality and outcomes
- Secure greater equity
- Create value
- Deepen collaboration

Our system priorities

- Employment and workforce
- Long term conditions
- Children and young people
- Mental health

Principles to underpin our system strategy development in NEL

North East London Health & Care Partnership

A new NEL Strategy Task & Finish Group has discussed some initial principles for the integrated care strategy and other strategic work for the partnership -

Supports alignment -

- To our ICS purpose and priorities (see Annex 1)
- To our strategic context in NEL –
  - Richly *diverse* communities
  - Unprecedented population *growth*
  - Widespread and severe *deprivation*
  - Historic *underinvestment*

As well as supporting alignment across different parts of our system

Built through co-production and engagement –

- Grounded in *data*, *evidence* and *insights* from our communities
- Shaped by empowered *clinical* and *care professional leadership*
- Rebuilding *trust* with our *communities*

Delivers the building blocks of our system -

- *Financial sustainability* and *value for money*
- *Equity of access, experience* and *outcomes* in all of our services
- Alleviating pressure on key services through a *population health approach*

Improves outcomes for our residents through a step change in ambition for –

- Tackling *inequalities*
- Focusing on *prevention*
- Accelerating *innovation*
- Securing greater *integration* and *collaboration*

The new system strategy landscape

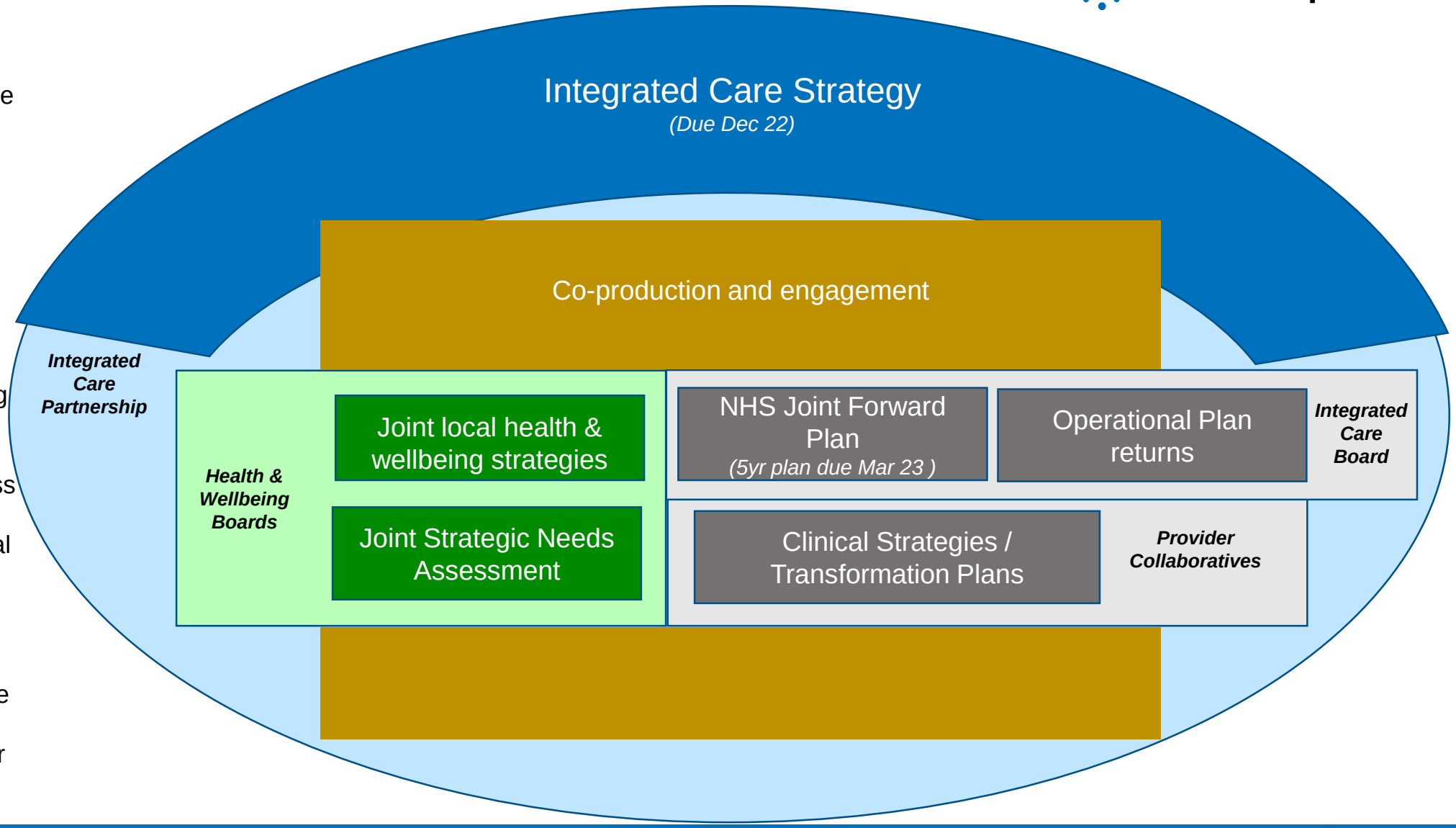
North East London Health & Care Partnership

Assumptions
The ICP Integrated Care Strategy (due Dec 22) will be the overarching strategy for the system; and development of it is the initial focus for a new NEL Strategy Task & Finish Group.

The ICP Strategy will set the local framework for the (new) NHS Join Forward Plan required by Mar 23 and our operational plan (now covering two years).

The ICP Strategy must address local JSNAs and there will need to be alignment with local health and wellbeing strategies.

Co-production and engagement with the full range of stakeholders including local people will be core to all of our system strategy work.



National requirements for integrated care strategies

ICP strategies should..

- Be based on JSNAs and other data and insights
- Reinforce subsidiarity and focus on system level actions
- Describe progress in relation to integration

Plus there is an expectation that agreeing shared outcomes within the ICS, quality improvement, and joint working under section 75 of the NHS Act 2006, to be important aspects of all strategies.

In the preparation of the integrated care strategy, guidance indicates that integrated care partnerships must involve the people who live and work in the area covered by the integrated care partnership including: Healthwatch; people and communities; providers of health and care services; voluntary, community, and social enterprise sector; and Health and Wellbeing Boards.

ICPs should also consider covering..

- Personalised care
- Health inequalities including meeting the needs of underserved groups
- Population health and prevention
- Health protection
- Babies, children, young people and their families
- Healthy ageing
- Workforce
- Research and innovation
- Data and information sharing

Next steps

- A new system Strategy Task & Finish Group met for the first time in August 22 to support the development of the Integrated Care Partnership's strategy in NEL and is now meeting regularly to ensure there is wide participation in the development of the strategy. The group will ensure that this and other related system strategies and plans address the key challenges for our population including tackling health inequalities.
- The Group includes representatives of provider collaboratives, place based partnerships and Healthwatch and is reporting to the ICS Exec Leadership Team via the chair, Zina Etheridge.
- We are also setting up a new Data and Analytics Working Group to support our system strategy work.
- An engagement plan is in development to ensure we have a process to support involvement of local people, key stakeholders and groups including local Health and Wellbeing Boards.
- We will also be drawing on HealthWatch and other local resources to utilise / gain community insights in support of our strategy work.
- A series of workshops are taking place across the Autumn, bringing key partners together to develop our four system priorities for the ICS feeding into the integrated care strategy. There will also be a further workshop on the cost of living.

Stakeholder workshops to develop our ICS priorities

North East London Health & Care Partnership

ICS priority	Date for stakeholder workshop
Long Term Conditions	Thursday 18 October
Employment, skills and training	Tuesday 1 November
Babies, Children and Young People	Thursday 3 November
Mental Health	Wednesday 9 November

Also:

Responding to the cost of living increase	Thursday 6 October

North East London
Integrated Care Board

NHS North East London ICB board

28 September 2022

Title of report	NHS North East London Approach to Winter Planning 2022-23
Author	Zina Etheridge, Chief Executive Officer
Presented by	Zina Etheridge, Chief Executive Officer
Contact for further information	Laura Anstey, Chief of Staff, l.anstey@nhs.net
Executive summary	This brief paper outlines the plans underway to prepare for winter across north east London for consideration by the Board. The plans are moving in line with our understanding of the challenges and the Board will receive a presentation with the most current picture of plans responding to these challenges.
Action required	Discussion
Previous reporting	ICS Executive Leadership Team
Next steps/ onward reporting	The winter plan will be a live document led across the system and will be adapted and refined in line with the changing position over the coming months, ensuring it is responsive and dynamic.
Conflicts of interest	N/A
Strategic fit	Our winter plan aligns to our wider ICS focus: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	Whilst health and social care are used to challenging winters, the current modelling and wider context suggest that we are facing a significantly more difficult winter than usual. This is due to a range of factors which include an anticipated difficult flu season, the potential for additional waves of Covid and a rise in other respiratory illnesses. Additional pressures caused by the cost of living crisis and rising energy prices could have a significant impact on cold and poverty related illness, particularly for vulnerable residents and those on low incomes. Workforce challenges are evident across the system, with some critical disciplines such as social care, nursing and midwifery particularly stretched. It is noteworthy that some settings experienced rates of demand in July this year higher than at any point during the most recent winter. With effective, system wide planning and collaboration we are well placed to ensure effective services and support for our residents.

Impact on finance, performance and quality	The Winter Plan, noted here as a live system level document to be further developed across partners, represents a significant body of activity to meet resident needs over the winter months. It is anticipated that the approach adopted will have financial implications as it requires redesigning, adapting and in some cases extending existing services, to ensure an equitable and joined up system response. The financial modelling to understand these implications has not yet been undertaken but all partners are aware of the significant financial pressures faced by each part of the system and the need to reshape what we do within existing resources where possible. The Winter Plan as envisaged is being developed to have positive impacts on our performance as a system and on the outcomes we achieve together for residents. The metrics underpinning our approach will be developed and reported as the Plan is finalised and implemented.
Risks	The system is already under significant pressure with high levels of demand touching all partners, as noted in the report. A number of residents are living with increasing acuity and complexity of conditions which require highly specialised responses for both long term and urgent presentations. There is a need to ensure a dual focus on community and urgent care provision and to retain a focus on system working at all levels. A fuller analysis of risk will be developed as the Plan is finalised across partners.

1.0 Introduction

This brief paper outlines the plans underway to prepare for winter across north east London for consideration by the Board. The plans are moving in line with our understanding of the challenges and the Board will receive a presentation with the most current picture of plans responding to these challenges.

2.0 Background

Whilst health and social care are used to challenging winters, the current modelling and wider context suggest that we are facing a significantly more difficult winter than usual. This is due to a range of factors which include an anticipated difficult flu season, the potential for additional waves of Covid and a rise in other respiratory illnesses. Additional pressures caused by the cost of living crisis and rising energy prices could have a significant impact on cold and poverty related illness, particularly for vulnerable residents and those on low incomes. Workforce challenges are evident across the system, with some critical disciplines such as social care, nursing and midwifery particularly stretched. It is noteworthy that some settings experienced rates of demand in July this year higher than at any point during the most recent winter. With effective, system wide planning and collaboration we are well placed to ensure effective services and support for our residents.

3.0 Aims and Objectives

Our objective is to ensure that the residents of north east London are able to access the care and support they need to keep them well this winter. This means:

- Helping people stay well, independent and healthy, preventing them needing acute levels of care as far as possible;
- Ensuring that we are planning for and delivering the capacity we need for those who do need it;
- Ensuring that people can access the right care at the right time, and which prevents them from becoming more unwell whilst they are waiting;
- When a resident has been admitted to hospital, ensuring that we have the right plans and support in place that they can move to a less acute setting and regain their independence as quickly as possible.

Bearing all this in mind, partners through the ICS Executive Committee and in Place Partnerships are focusing on our planning for winter. This summary paper outlines current planning and arrangements to ensure a robust, collaborative and effective response. This will build on the usual winter planning we undertake bringing together place based, acute, community, mental health, primary and social care and wider provider level planning and preparation, ensuring that all partners across the system are working together to support people to stay well and at home where possible.

It will ensure we meet the eight core objectives set in NHSE Winter Requirements Letter which are listed in Appendix A.

The ICS executive will play a coordination and oversight role, supporting system partners in developing their own winter plans, including a joined up place based response, sharing best practice, monitoring the delivery of services and working collaboratively with system partners to manage performance, support mutual aid and ensure delivery. The ICS Executive will act as the central point of escalation during periods of challenge, enabling all partners to collectively agree to actions to support the system and, where necessary, take decisions regarding service prioritisation and support.

4.0 Supporting people to stay well at home

The core ingredients of our work in this area are:

- Demand management – making sure our residents get the best care in the right place first time via urgent community response services, an integrated falls service, homeless pathways and proactive support to high impact users across all boroughs. We will ensure consistency of services so that all our residents can expect to be supported to a common, core level, and single system providers (such as London Ambulance Service) can most effectively work with us.
- Additional support to nursing and residential care homes to keep residents in their home setting as far as possible – wrapping system support around those homes that need it the most and reducing urgent care interventions where possible
- Virtual wards – these allow patients to get the care they need at home safely and conveniently, rather than being in hospital. Across north east London these support discharge and community set up (initially for frail patients and acute respiratory infections).
- Anticipatory care – ensuring this model connects effectively across the system to target those most at risk over the winter and provide early, targeted health or care interventions to prevent deterioration in their health, thereby supporting their independence, keeping them well in their usual home setting (whether this is their own home or a care home) and preventing the need for admission. Where necessary linking in with their families, usual care staff, GPs or other services.
- Exploring enhanced domiciliary offers which build on the expertise of care workers to provide for residents with greater complexity in their own homes
- An effective under 5 respiratory service which sees children in the community, but ensures capacity in acute settings for those in greatest need
- Place based planning led by place partnerships with the active engagement of local systems. These plans should focus on addressing the impact of the cost of living emergency on the determinants of the health and wellbeing of residents, supporting early intervention and community-based models to keep people well.
- Our vaccine programmes – and in particular our work on flu and Covid vaccinations.

5.0 Supporting access to Urgent and Emergency Care

In order to ensure that residents are able to access the urgent or emergency care they need we are:

- Provider organisations have all developed winter plans in conjunction with all system partner plans, particularly place based plans. These should ensure mitigation of any capacity and demand gaps and outline how they will work together to manage pressures.
- Supporting 111/999 services - by focusing on a shared understanding of risk, a shared focus on supporting people to stay at home with primary, community and social care support and enabling access to alternatives to urgent care
- Urgent Treatment Centre models of delivery and integration with A+E services, GP extended hubs and out of hours services (as appropriate) – ensuring we have a

joined up approach to keeping people at home with the support they need, facilitating access to primary care and building in effective social care packages at pace

- Supporting emergency departments to run smoothly – removing blocks that prevent people moving into appropriate settings within the hospital or back home and reducing 12 hour delays, improving access to mental health services for children and adults
- Infection Prevention Control – maintaining safety, especially in light of increased risks from flu and Covid resurgence

6.0 Supporting people to leave hospital as soon as they are ready

There will be a partnership approach to discharge planning, ensuring it is joined-up with a clear link to reablement and rehabilitation, in order to minimise the risk of people being readmitted to hospital and the need for long term health and or care input. Creating and maintaining additional care provision capacity is important but in itself will not solve the challenges that stop people being able to leave hospital as soon as they are medically fit into an environment that supports their continued recovery. We know we need to concentrate on our collective effectiveness in the way we work together to discharge patients, particularly those with more complex or ongoing care needs. Health and social care working in partnership with patients and their families at each point of the process throughout the hospital stay, from preparatory actions within hospital, to rapid and robust assessments, placements and transfer. Working in a way that brings together the shared contributions of the NHS and local government, predominantly through social care, with residents and their families and the wider community sector. Particular focus will be put on maintaining discharge 7 days a week.

7.0 Supporting access to primary care

Primary care is a critical part of the system and underpins our response across all elements of winter planning. Primary care is the cornerstone of winter illness prevention with an intensive autumn focus on immunisation for flu and Covid, in addition to a polio booster for under 9s. Support for those needing urgent appointments is balanced against a continued focus on the care of people with long term conditions, frailty and support at the end of life. This will be achieved through improving access to same day care, extended provision, increasing direct referral from 111 services, identification and proactive support for high intensity users and the support to nursing and care home settings. Given the focus on both face to face and virtual consultations digital infrastructure support is also being rolled out. . We also need, through our communications and winter health campaigns to help patients to make the right choice of service, first time, by building understanding and awareness of the enhanced access now available.

8.0 Supporting the workforce

Our workforce is the most critical element of our response and we recognise the need to work together to support our workforce as a system. All areas of the workforce are facing some level of challenge due to competing pressures, wage inflation in other sectors and the longer-term impacts of EU exit, requiring a system wide approach to how we can support the workforce across winter. We recognise the specific challenges in some disciplines and sectors in both recruitment and retention, for example in social care and nursing.

9.0 Supporting the system

The ICB is working through how the current incident response function can work more effectively with system surge and capacity teams to support partners across the system and the broader approach to winter planning and system resilience 24/7.

10.0 Winter Messaging Campaign

Our winter campaign will have three broad themes aimed at prevention, care navigation and supporting the impact of the cost of living crisis where we can.

1) **Preventing** respiratory illness by encouraging maximum uptake of flu and covid vaccinations for residents and staff – offering individual and patients protection and supporting services through maintaining staff health and wellbeing and lower incidence of ill health
2) **"Your route to health"** guiding people to access the best option for their need and making them aware of what each service can offer e.g. using 111, community pharmacy, self-care. mental health crisis services and encouraging registration with GPs rather than reactive or crisis attendance at A+E
3) Cost of living – financial help and advice on NHS care costs and prescriptions.

11.0 Next steps

The winter plan will be a live document led across the system and will be adapted and refined in line with the changing position over the coming months, ensuring it is responsive and dynamic.

Overall it will be underpinned by strong governance, relationships, leadership and place-based delivery. The North East London Programme executive, chaired by the ICB CEO, will provide system oversight. In addition, strong clinical and professional leadership and subject matter expertise will ensure the plan is working in the right way, managing risk and effectively managing quality across services.

Appendix A – NHS winter plan objectives and metrics

Eight core winter objectives

1) Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.

2) Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.

3) Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.

4) Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.

5) Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.

6) Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.

7) Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.

8) Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

National metrics for urgent and emergency care:

- 111 call abandonment
- Mean 999 call answering times
- Category two ambulance response times
- Average hours lost to ambulance handover delays per day
- Adult general and acute type one bed occupancy
- Percentage of beds occupied by patients who no longer meet the criteria to reside

NHS North East London ICB Board

28 September 2022

Title of report	Finance and Performance Overview
Author	Finance and Performance team
Presented by	Henry Black, Chief Finance and Performance Officer
Contact for further information	henryblack@nhs.net
Executive summary	**Key Items** • The report outlines the year-to-date financial position for the ICS and the ICB. The ICB budgeted allocation to the end of August was £1,665m. • The ICS and ICB have reported an unfavourable system variance to plan at month 5 of £42.8m, primarily due to inflationary pressures and slower than planned delivery of system savings and cost improvements. • The system has reported a forecast outturn to plan. • The report includes the June performance position, outlining key issues across a number of areas including urgent and emergency care. • The report updates on the latest position on health inequalities via formal section 256 agreements with local authority partners.
Action required	• Note the content of the report and the key risks to the expected year-end breakeven position. • Note the performance report • Recommend for approval the ICB Plan / Budget • Recommend for approval the Health Inequalities section 256 agreement
Previous reporting	N/A
Next steps/ onward reporting	Future financial and risk updates will be given to the ICB Board, ICB Finance, Performance and Investment Committee and the ICB Audit and Risk Committee.
Conflicts of interest	No conflicts of interest
Strategic fit	NEL wide plans are set on the financial resources available. The report provides an update of financial performance against the plan.
Impact on local people, health inequalities and sustainability	The report includes an update on health inequalities funding, including a request to approve section 256 agreements with local authority partners.

Impact on finance, performance and quality	Delivery of the financial plan and meeting the control total is a mandated requirement.
Risks	Financial risks are outlined in the paper. Key risks have been identified as inflation, efficiencies and funding availability for elective recovery. Further system risk has been identified in relation to workforce and pay pressures with partners and system wide investment programmes.

NORTH EAST LONDON INTEGRATED CARE BOARD – FINANCE AND PERFORMANCE REPORT

Executive Summary

At month 5 the ICB and the wider ICS are operating in an economic climate facing significant pressures and uncertainty. As a result, the year-to-date position for the system (the gross position for the six statutory NHS organisations) is a £48.1m deficit, which is £42.8m variance to plan. This constitutes a £47.3m adverse variance reported by the system providers and a £4.5m favourable variance reported by the ICB.

	Year to date			Forecast Outturn		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Total Provider Position	**(5.3)**	**(52.6)**	**(47.3)**	**0.0**	**0.0**	**(0.0)**
ICB (CCG) Position	0.0	4.5	4.5	0.0	0.0	0.0
Total System Position	**(5.3)**	**(48.1)**	**(42.8)**	**0.0**	**0.0**	**(0.0)**

The main drives to this position are under delivery of efficiency and cost improvement targets, inflation, temporary staffing pressures and run rate pressures relating to continuing health care and prescribing.

Despite the pressures, the forecast position is reported to be in line with plan. To enable this position to be delivered a number of mitigations and actions will be required in the final seven months of the financial year. The forecast position, therefore, includes a significant level of financial risk. The risk across the six statutory organisations is estimated to be approximately £90m.

ICB Plan / Budget Approval

The final system operating plan was submitted to NHS England (NHSE) in June 2022. This included the financial plan for both the ICB and system providers. The ICB element of the plan was endorsed by the NEL CCG Finance Committee in June 2022 and is now presented to the ICB Board for formal approval. The system provider plans have each being signed off by their respective boards.

The finance plan was split into two periods, quarter 1 for the CCG element and quarters 2 to 4 for the ICB. Final outturn will be monitored against the total budget and the expectation is that the ICB will breakeven against the planned budget.

The plan included the opening budget and an element for indicative budgets that will be transferred to the ICB by regulators over the remainder of the financial year. The opening budget for the CCG / ICB was £3994.8m. **It is recommended that the ICB Board formally agrees the ICB budget.**

The table below shows the submitted ICB plan, split by programme areas.

NEL ICB 2022-23	Q1 - CCG Budget £m	Q2-4 - ICB Budget £m	Total Opening Budget £m
Acute	552.9	1,659.3	**2,212.2**
Mental Health & LD	103.0	309.7	**412.7**
Community Health Services	84.4	277.0	**361.4**
Continuing Care	43.9	132.2	**176.1**
Other Programme	27.9	72.7	**100.6**
Prescribing	63.3	188.6	**251.9**
Primary Care Services	20.1	61.6	**81.8**
Primary Care Co-Commissioning	89.9	269.6	**359.5**
Running Costs	9.7	29.1	**38.7**
TOTAL EXPENDITURE	**995.1**	**2,999.7**	**3,994.8**

Whilst the budget was set at a NEL level for 2022/23, there is further work on developing a financial strategy at a place level and at a NEL level. This will continue to develop throughout 2022/23 and 2023/24.

Month 5 Financial Position

At month 5 the ICB has received the opening budget and an additional £14m, relating to specific programmes including virtual wards, post covid, system development funds and cancer alliance, as shown in the table below.

Resource Limits	Annual Plan £m
CCG Plan (Months 1 - 3)	995.6
ICB Plan (Months 4 - 12)	2,999.7
Resource Allocations M4-5	14.0
Total	**4,009.4**

The system provider budgets have been signed off by their boards and reporting across the system is prepared using these budgets.

The month 5 year-to-date position across the NEL system is a overspend variance to plan of £42.8m. This is made up of a provider overspend variance of £47.3m with an ICB underspend position of £4.5m.

The reported year-to-date variance is summarised by statutory organisation in the table below.

Organisations	Year to date			Forecast Outturn		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
BHRUT	(3.5)	(20.8)	(17.2)	0.0	0.0	0.0
Barts Health	0.0	(24.8)	(24.8)	0.0	0.0	0.0
East London NHSFT	(1.2)	(2.9)	(1.6)	0.0	0.0	0.0
Homerton	(0.5)	(4.1)	(3.7)	0.0	(0.0)	(0.0)
NELFT	0.0	0.0	0.0	0.0	0.0	0.0
Total NEL Providers	**(5.3)**	**(52.6)**	**(47.3)**	**0.0**	**0.0**	**(0.0)**
NEL ICB	0.0	4.5	4.5	0.0	0.0	0.0
NEL System Total	**(5.3)**	**(48.1)**	**(42.8)**	**0.0**	**0.0**	**(0.0)**

The majority of the year-to-date pressures are held within BHRUT and Barts. All organisations are currently reporting a forecast outturn to plan despite the year-to-date pressures faced.

The key drivers for overspends at a system level are as follows;

- Inflation – providers have reported additional costs in relation to inflation being higher than planned levels.

- Payroll costs – providers have reported pressures in relation to pay, including agency staffing. Average monthly pay across all providers is £231.9m and is on an upward trajectory compared to the same period last year. Provider payroll spend is shown in the table below.

Organisation	M1 £m	M2 £m	M3 £m	M4 £m	M5 £m	Actual YTD £m	YTD Av. Run Rate £m	Variance from prior month %	Average 21/22 run rate M 1- 5 £m
Homerton	22.1	22.1	22.2	21.6	22.4	110.3	22.1	3.4%	20.4
Barts	99.7	99.7	99.7	101.5	100.1	500.6	100.1	(1.4%)	92.9
ELFT	33.3	33.3	33.3	34.1	34.4	168.4	33.7	0.8%	31.3
BHRUT	42.6	42.6	42.7	42.6	42.9	213.4	42.7	0.9%	40.3
NELFT	33.6	33.6	33.3	33.9	32.6	166.9	33.4	(4.0%)	30.9
Total Providers	**231.2**	**231.2**	**231.3**	**233.7**	**232.4**	**1,159.7**	**231.9**	**(0.6%)**	**215.9**

- Efficiency and cost improvement plans - the total system efficiency and cost improvement plan at month 5 is £66.1m. Providers and the ICB have assessed performance against this target and are reporting slippage against the plan of £21.3m. These plans included an overall reduction in payroll costs which are not been seen across the system. Of the efficiency and cost improvement plans delivered, the system is falling short in delivering the benefits recurrently. This means that efficiency and cost improvements remain an outstanding risk for the delivery of in year financial balance and the recurrent impact into financial year 2023/24.

- By the end of the financial year there is expected to be some recovery in the delivery of efficiency plans and the system shortfall in the forecast position is expected to be £11.4m.

  Efficiency and cost improvement by statutory provider are shown in the table below.

Efficiencies	Year to date			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Total Provider Effieciency	**18.0**	**22.2**	**4.3**	**40.1**	**57.1**	**17.0**
BHRUT	11.8	3.1	(8.7)	40.7	40.7	0.0
Barts	25.0	20.2	(4.8)	60.0	60.0	0.0
ELFT	3.9	1.1	(2.8)	15.0	7.2	(7.8)
Homerton	6.0	4.9	(1.1)	15.5	11.9	(3.6)
NELFT	5.8	5.8	(0.0)	14.0	14.0	0.0
Total Provider Effieciency	**52.6**	**35.2**	**(17.4)**	**145.2**	**133.8**	**(11.4)**
NEL ICB	13.5	9.6	(3.9)	40.8	40.8	0.0
Total System Efficiency	**66.1**	**44.8**	**(21.3)**	**186.0**	**174.6**	**(11.4)**

- Elective Recovery. The system has been given specific funds to help deliver elective recovery though the reduction of waiting lists. At month 5 targets have not been met and therefore £15m of funds have been held within the ICB year-to-date position and a correlating pressure within provider accounts. If funds are clawed back by regulators the system position would worsen by £15m.

- Run rate pressures in the ICB – there is a continued run rate pressure in CHC relating to high cost package and observation costs.

2022/23 Forecast

The expected forecast position for the NEL system is a breakeven position. However, the straight line forecast at a system level based on the current run rate shows that there is a risk of a significant overspend, and organisations will work through further action that can be taken to address this. The forecast across the NEL system will be reviewed at month 6.

Risks and mitigations

As outlined above the ICB and ICS are facing year-to-date financial pressures but have reported a forecast outturn to plan position. The total gross risk identified at month 5 across the system is £162.8m. Mitigations of £72.3m have been identified leaving a residual risk of £90.5m. This will need to be eliminated to allow delivery of the system plan.

The table below summarises the risks identified.

Organisation / System wide	Description of risk	Risk Level	Potential Impact before mitigations £m	Potential Impact after mitigations £m
Barts	Inflation	High	(27.0)	(27.0)
BHRUT	Efficiencies /waste	High	(29.0)	(14.0)
ELFT	Delivery of efficiencies	High	(7.8)	(5.5)
Homerton	Temporary staffing / efficiencies	High	(6.0)	(4.0)
NEL ICB	Run rate risk	High	(35.0)	0.0
System Wide	Capital : rejected schemes for TIF	High	(22.0)	(22.0)
System Wide	Delivery of ERF	High	(36.0)	(18.0)
Total Risk			**(162.8)**	**(90.5)**

NB – targeted investment fund referred to as TIF and elective recovery fund referred to as ERF.

- **Inflation –** inflation is flagged as a major risk to providers. To date the areas causing the greatest pressures are energy and index linked pressures for buildings and insurance. Additionally, the ICB is starting to see inflationary price pressures in prescribing and other areas, including packages of care.
- **Workforce** – all NEL providers are overspending against workforce targets. There are pay award pressures and a reported overspend against the provider agency cap at the end of quarter 1. A further risk, relating to pay pressures has also been identified in local authority budgets.
- **Elective recovery** – this remains a risk pending clarification from NHSE about the treatment of the shortfall against the target. The gross risk to the system is £36m.
- **Capital programme** – inflation is causing a drop in purchasing power and extended lead times for raw materials and completed goods.
- **Efficiencies and cost improvement** – providers have flagged a shortfall in delivery at month 5 of £17.4m. Whilst the forecast position assumes greater delivery of efficiencies towards year-end, providers have flagged an efficiency / waste / agency gross risk of £42.8m. Where there are efficiencies built into ICB budgets, there are still unidentified efficiencies. The risk of non-delivery of the ICB target is £35m.
- **Activity and prices increase in continuing health care** – the pressures seen at the end of 2021/22 have continued. Additionally, there is a risk moving into 2023/24 in relation to costs associated with the hospital discharge pathway.
- **Non recurrent measures supporting recurrent spend** – both providers and the ICB have non-recurrent funds supporting spend in 2022/23 (for example, Covid funds). This supports the in-year position but may result a pressure in 2023/24.

Potential mitigations to offset the financial risks identified include;

- **Balance sheet flexibilities** – all organisations to utilise balance sheet flexibilities to manage the position as a system.
- **Delivery of efficiency plan** – organisations to continue to identify and deliver efficiencies.
- **Investments** – review new and pipeline investments, including allocations to manage the risks in the system.
- **Workforce** – review workforce productivity, agency usage and vacancy freezes. Additionally, NHSE have applied a provider agency spend cap applicable to individual organisations.

System Performance

This summary covers the main Operating Plan metrics and other key performance requirements including:

- Urgent and Emergency Care
- Elective Care and Outpatients
- Cancer and Diagnostics
- Mental Health, and
- Out of Hospital Services

Urgent and Emergency Care information is up to July 2022, other data presented is up to June 2022.

a) Urgent and Emergency Care

Acute Trust Emergency Departments (ED) continue to be significantly pressured with NEL being ranked lowest in London according to NHSE measures. In July-22, only 66.15% of patients were seen within 4-hours of arrival at ED, BHRUT being the most challenged with the highest number of patients waiting more than 4 hours from arrival, and over 12 hours from a decision being made that the patient requires admission. The number of patients attending ED has increased over the last 6-months, with increased attendances most significantly at BHRUT Type 1 (most acute patients). The number of patients requiring admission following attendance at BHRUT has also increased over the last 6-months. There are also significant delays for patients arriving by ambulance in NEL with 1,219 patients in Jun-22 waiting more than 1-hour to be transferred from London Ambulance Service care following arrival at hospital. Queen's Hospital is seeing the longest delays following arrival by ambulance at hospital.

	Metric	Latest Published July-2022				Latest Weekly 31-July-2022			
		Achievement	Trajectory	Actual	Change from prev. Month	Achievement	Trajectory	Actual	6-Week Trend
UEC	60 min Ambulance Handovers - (volume) * LATEST JUN-22	⊗	National Req. ZERO	1,219	▲		National Req. ZERO	162	▲
	12-hour Trolley waits (volume)	⊗	National Req. ZERO	1,043	▲		National Req. ZERO		
	A&E Attendances (volume)		N/A	81,440	▼			17,710	▼
	A&E 4-Hour All Type (Performance %)	⊗	National Req. 95%	66.15%	▼			67.48%	▲
	A&E 4-Hour Type 1 (Performance %)	⊗	National Req. 95%	54.81%	▼			56.67%	▲
	Admissions (volume)			11,195					

KEY	
	Latest monthly and latest weekly position where appropriate are shown as RAG : ✓ ON × OFF track vs. trajectory. Weekly position is indicative only.
	Change from prev. month indicates movement (up or down) from the previous month based on validated published data to provide the formal position: ▼/▲ deterioration ▼/▲ improvement
	6-Week Trend indicates movement (up or down) over the last 6-weeks based on un-validated weekly data to provide indication of current level of risk: ▼/▲ deterioration ▼/▲ improvement

b) Elective Care and Outpatients

Despite the continued pressure and high activity levels in ED and the resultant level of non-elective admissions, there has been some improvement in elective performance, although the number of patients waiting for 2 or more years for planned care remains the highest in London. There are also a number of performance disparities and inequalities across NEL providers. As at the end of June, 186 patients were waiting, or which 183 were with Barts Health. In addition to these patients with long waits, the focus is now on seeing and treating patients who will have been waiting 18 months (78 weeks or more).

Overall the waiting list for planned care is increasing, with increases at all providers; the most significant increase is at BHRUT overall, particularly for those waiting for outpatient appointments. The Barts Health's non-admitted waiting list is also increasing, and to a lesser extent, the number of patients waiting for inpatient appointments and surgery is also

increasing. Activity levels to treat patients remain a challenge and are not at the required level to reduce the waiting list size. Consultant outpatient activity to treat patients in June 2022 was at 96% of pre-pandemic activity levels in June 2019. Homerton Healthcare is the only provider achieving activity in excess of 2019 levels.

Inpatient activity to treat patients in June 2022 was at 84% of June 2019, with BHRUT closest to achieving pre-pandemic levels, and Barts Health being the most challenged.

GPs are able to access specialist advice and guidance to reduce outpatient demand with 22% of first outpatient appointments now being managed through this route; GP access for specialist advice remains low in the BHRUT community compared to those accessing through Barts Health and Homerton Healthcare. Patients are also able to initiate their own follow up appointments for 0.8% of all outpatient appointments, NEL was just below the London average of 0.8% for the month.

	Metric	Latest Published June-2022				Latest Weekly 31-July-2022			
		Achievement	Trajectory	Actual	Change from prev. Month	Achievement	Trajectory	Actual	6-Week Trend
Elective	PTL Total (volume)	✓	199,503	198,045	▲	●	199,883	198,813	▲
	>104ww (volume)	✗	158	186	▼	●	70	68	▼
	>78ww (volume)	✓	1,455	1,315	▼	●	1,240	1,138	▼
	>52ww (volume)	✗	8,255	9,035	▲	●	7,893	9,399	▲
	Clock Stop Activity (%BAU)	✗	86.6%	80.7%	▼			7,194	▼
	Inpatient Elective spells (% of BAU)	✗	96.0%	84.6%	▼	●	95.93%	77.40%	▼
	Outpatient Attendances - (Consultant Led) (% BAU)	✗	101.8%	96.0%	▼	●	97.38%	103.18%	▼

	Metric	Latest Published June-2022			
		Achievement	Trajectory	Actual	Change from prev. Month
Outpatient Transformation	First Request for A&G/Specialist Advice	✓	13,264	13,794	▼
	First Request for A&G/Specialist Advice as % of OPFA	✓	National Req. 16%	21.81%	▼
	Moved or Discharged to PIFU. (E.M.34 PIFU)	✗	3,146	1,766	▼
	PIFU as a % of OPA	N/A	National Req. 5% in Mar-23	0.83%	▲
	OP Virtual Activity	✗	49,142	44,795	▼
	OP Virtual Activity as a % of All Outpatient	✗	National Req. 25%	20.97%	▲

NB - Outpatient follow up appointments referred to OPFU, Patient initiated follow up referred to as PIFU, Consultant advice and guidance referred or as A&G.

KEY	
	Latest monthly and latest weekly position where appropriate are shown as RAG : ✓ ON × OFF track vs. trajectory. Weekly position is indicative only.
	Change from prev. month indicates movement (up or down) from the previous month based on validated published data to provide the formal position: ▼/▲ deterioration ▼/▲ improvement
	6-Week Trend indicates movement (up or down) over the last 6-weeks based on un-validated weekly data to provide indication of current level of risk: ▼/▲ deterioration ▼/▲ improvement

c) Cancer and Diagnostics

The faster diagnosis and treatment standard for cancer patients is the best across London, meaning patients receive a diagnosis quickly in NEL. In Jun-22, NEL delivered seven of the nine cancer waiting time standards. However, treatment for patients within 62 days from urgent GP referral still requires improvement. The current cancer backlog is attributed to challenges associated with diagnostic imaging delays, increased referrals and turnaround times for diagnostic reports.

NEL continues to have the highest volume of patients waiting for an imaging investigation in London in June-22, with waits over 6 weeks the highest at Barts Health and BHRUT, predominantly driven by MRI and CT.

	Metric	Latest Published June-2022				Latest Weekly 31-July-2022			
		Achievement	Trajectory	Actual	Change from prev. Month	Achievement	Trajectory	Actual	6-Week Trend
Diagnostics	>6ww Backlog (volume)			11,952	▼			14,518	▼
Cancer	31 Day Treated (volume)	⊗	519	454	▼				
	62 Day Backlog (volume)	⊗	568	759	▲	●	546	593	▼
	104 Day Backlog (volume)			164	▲			0	↔
	FDS (Performance %)	✓	75.61%	79.49%	▲				

d) Mental Health

Overall Mental Health performance remains mixed across NEL, and it should be noted that further variation exists between boroughs, where historical differences in service provision remain. Some indicators in June show improvement at the end of 2021/22, although there continues to be risk in maintaining the improvement through the remainder of the year.

The table below shows the key measures for our mental health services. These include:

- Improved Access to Psychological Therapies (IAPT)
- Dementia diagnosis
- Physical health checks for people with Serious Mental Illness (SMI)
- Perinatal mental health support to women, and
- Children and Young Peoples Mental Health access and activity (CAMHS Access)

The number of people accessing IAPT services (talking therapies) has not been met in June 2022. Redbridge remains below trajectory, and Waltham Forest has deteriorated since April 2022 and is also below trajectory. An internal recovery plan has been worked up.

The estimated diagnosis rate for people with dementia has remained stable but is below target and unlikely to hit the national target in the operating plan.

The number of people diagnosed with serious mental illness (SMI) who have received a physical health assessment also has remained under target since December 2019, with only City and Hackney achieving over the last 4 quarters.

The number of women accessing perinatal mental health services is above target for June 2022, although concerns remain about the full year delivery. A formal recovery plan has been submitted as part of the Operating Plan return.

The number of children and young people (CYP) aged under 18 receiving at least one contact is showing increasing levels of access. In addition, the number of people receiving treatment within 2 weeks of referral with 'First Episode Psychosis' has remained stable over recent months.

The number of children and young people with eating disorders being seen within 4 weeks (routine referrals) and within 2 weeks (urgent referrals) of referral is under target, largely due to the impact of the Covid pandemic.

		Latest Published			
	Metric	Jun-22	*Trajectory*	*Actual*	Change from prev. Month
Mental Health	IAPT Access	✗	*4,675*	*4,065*	▼
	Dementia Diagnosis	✗	*66.70%*	*59.90%*	▼
	SMI Physical Health Checks	✗	*60.00%*	*44.52%*	▼
	Perinatal	✓	*6.36%*	*6.59%*	▲
	CYP Access	✓	*21,680*	*22,350*	▲
	EIP	✓	*60.00%*	*71.43%*	▼
	CYP ED Urgent	✗	*95.00%*	*91.38%*	▲
	CYP ED Routine	✗	*95.00%*	*86.02%*	▲

KEY	
	Latest monthly position where appropriate are shown as RAG : ✓ ON × OFF track vs. trajectory.
	Change from prev. month indicates movement (up or down) from the previous month based on validated published data to provide the formal position: ▼/▲ deterioration ▼/▲ improvement

e) Out of Hospital Services

The number of GP appointments carried out in June is reduced on the previous month and further below planned volumes. Work is underway to increase capacity in primary care to support winter pressures, including further capacity through extended access services

		Latest Published June-2022			
Out of Hospital (Monthly)	Metric	Achievement	Trajectory	Actual	Change from prev. Month
	Appointments in General Practice	✗	1,130,841	861,953	▼

NEL achieved is trajectory for Q1 (11%), delivering health checks for over 19% of registered learning disability residents. The latest data indicates community waiting lists for both CYP and Adults are above trajectory for Q1 of 2022. The latest snapshot data (May-22) indicates the Q1 target of 31,544 will not be met. Reporting is not yet available at borough level.

		Latest Published Q1 22/23			
Out of Hospital (Quarterly)	Metric	Achievement	Trajectory	Actual	Change from prev. period
	E.K.3 Learning disability registers and annual health checks delivered by GPs	✓	11.29%	19.11%	↔

		Latest Published Q1 22/23			
Out of Hospital (Quarterly)	Metric	Achievement	Trajectory	Actual	Change from prev. period
	E.N.1 Personal Health Budgets	✗	3,664	2,976	↔

		Latest Published Q1 22/23			
Out of Hospital (Quarterly)	Metric	Achievement	Trajectory	Actual	Change from prev. period
	E.T.1 2-hour Urgent Community Response (UCR) care contacts - Count of 2-hour UCR first care contacts delivered within reporting quarter		1,634	N/A	↔

		Latest Published Q1 22/23 * Latest is May-22			
Out of Hospital (Quarterly)	Metric	Achievement	Trajectory	Actual	Change from prev. period
	E.T.2 Community services waiting list-Number of patients waiting at a point in time aggregated for a) in scope CYP and b) in scope Adult services	✗	31,544	50,189	▲

Health Inequalities Funding via a formal Section 256 (s256)

There is £6.6m included in the 2022/23 allocations to ICB's for tackling health inequalities. In March 2022 the ICS Executive Management Team agreed that the majority of the funding (£6.32m) would be allocated to place, providing the opportunity to:

- Support leadership for tackling health inequalities through the Place Based Partnerships;
- Support improved understanding of the health inequalities affecting local communities;
- Maximise and accelerate local plans to tackle inequalities in heath and care;
- Enhance community resilience and widen participation.

Pot A was an equal share of £3.5m of the total fund. Each place based partnership submitted plans for how they would spend the additional allocation of £0.5m each. This recognised that health inequalities exist in all places across NEL and that each place based partnership would benefit from ring fenced funding to develop leadership, partnership working and capacity building for health inequalities locally.

Additionally, places were asked to submit further proposals for up to an additional £0.6m against a discretionary fund (pot B). Place based partnerships generated over 50 project proposals that were evaluated by an internal panel against a set of transparent funding criteria. Proposals were selected on their potential to make the greatest impact to health inequalities.

The total agreed values by place are detailed in the table below:

Place	Pot A £m	Pot B £m	Total £m	Nominated Fundholder	Local Authority Signature
B&D	0.50	0.60	1.10	London Borough of Barking and Dagenham	Y
Havering	0.50	0.25	0.75	London Borough of Havering	N
Redbridge	0.50	0.29	0.79	London Borough of Redbridge	N
Tower Hamlets	0.50	0.40	0.90	London Borough of Tower Hamlets	Y
Newham	0.50	0.49	0.99	London Borough of Newham	N
Waltham Forest	0.50	0.39	0.89	London Borough of Waltham Forest	Y
C&H	0.50	0.40	0.90	London Borough of Hackney	Y
TOTAL	**3.50**	**2.82**	**6.32**		

Place based partnerships have nominated local authorities to hold and administer the funds, via a formal section 256 agreement (s256). S256's have been shared with the local authorities. Four of the seven S256 agreements have been signed off by the local authorities. The other three are still being discussed and revisions to the wording made as necessary.

The ICB scheme of reservation and delegation (SORD) required that the award be approved by the ICB Board or Finance and Performance Investment Committee.

The ICB Board is, therefore, recommended to approve and sign off the locally agreed s256 agreements for Barking and Dagenham, Tower Hamlets, Waltham Forest and City and Hackney. Approval is also sought to give delegated authority to the ICB Chief Executive and Chief Finance and Performance Officer to sign off Havering, Redbridge and Newham agreements once the necessary document revisions have been agreed.

Conclusion / Recommendations

The ICB Board is asked **to note** the contents and the month 5 year-to-date and forecast positions, including the financial risks that remain with regards to the planned breakeven position.

The ICB Board is asked **to note** the contents of the June performance report.

The ICB Board is **recommended to formally approve the ICB plan / budget** submitted in June 2022.

The ICB is **recommended to formally approve the s256 agreements** for four of the seven boroughs and to **formally approve delegated authority** to the ICB Chief Executive and Chief Finance and Performance Officer to sign off the remaining three boroughs.

Author: Finance and Performance team, 15 September 2022.

North East London
Integrated Care Board

NHS North East London Board Meeting

28 September 2022

Title of report	Governance update and outcomes of July board development
Author	Marie Price, Director of Corporate Affairs
Presented by	Charlotte Pomery, Chief Participation and Place Officer
Contact for further information	marie.price9@nhs.net
Executive summary	Since the first meeting of the Board on 1 July, there has been good progress in establishing the organisation and system governance arrangements. The Board held the first development session in late July, which focused on how the Board will work together, along with addressing some actions following the first meeting of the Board. The remaining Board members from the local authorities and community and voluntary sector are now agreed. All of the seven places have held or will hold their inaugural meetings of the place sub-committees, agreeing their terms of reference this month. Nominees to the system Executive Committee have been agreed, with all five local authority members now included. The wider Integrated Care Partnership (ICP) – our North East London Health and Care Partnership steering group met during the first week of September. The group will scope out the wider work of the partnership with an initial focus on the development of the system integrated health and care strategy.
Action required	To note and comment on progress to date and next steps To discuss the proposed decision making principles and delegate production of final set to Chair and Director of Corporate Affairs To note and approve recommendations as set out in section 3. To formally: • Approve the changes to the Standing Financial Instructions (SFIs) • Approve the changes to the membership of the quality, safety and improvement committee

Previous reporting	Initial discussion at the ICB Board held on 1 July and subsequent Board development session held on 20 July 2022.
Next steps/onward reporting	The Board will receive a further update and recommendations on the ICB's governance and delegation arrangements in November, through an updated Governance Handbook, with a more fundamental review to follow before April 2023.
Conflicts of interest	Not applicable
Strategic fit	Links to overall design and governance of the new integrated care system as established on 1 July 2022.
Impact on local people, health inequalities and sustainability	The new inclusive governance is designed to support the new organisation and system to make improvements to access, experience and outcomes for local people - with an overall focus on tackling health inequalities.
Impact on finance, performance and quality	There are no immediate financial implications.
Risks	There are no immediate risks identified.

Governance Update and Outcomes of July Board Development

1.0 Background

1.1 At the inaugural meeting of the NHS North East London Board, the governance policies and committees for the organisation, as set out in the Governance Handbook, were approved in principle. The Board noted that further national guidance was expected from NHS England, which would permit considerable delegation of integrated care board (ICB) functions. The Board recognised the need for committee leads across partners to meet to further discuss their membership and scope. These are taking place throughout September.

The Board agreed to receive a further update and recommendations on the ICB's governance and delegation arrangements in November through a revised Governance Handbook, with a more fundamental review before April 2023. This will follow a 'test and learn' phase, after which we will further refine arrangements and by which time extensive delegation will be permitted.

2.0 Progress since July

2.1 Board member and participant update: As highlighted in the Chair's report, the remaining members of the ICB board have now been confirmed, with the local authorities nominating Mayor Philip Glanville from the London Borough of Hackney and Councillor (Cllr) Maureen Worby of the London Borough of Barking and Dagenham. Mayor Glanville and Cllr Worby are part of a wider group of local authority leaders who will meet in advance of each Board meeting to share perspectives. The voluntary, community and social enterprise (VCSE) umbrella bodies have nominated Caroline Rouse of Compost Newham to be the VCSE collaborative member in the first instance, bringing the local sector's perspective to Board meetings.

Our Healthwatch Collaborative has also agreed to nominate a participant observer to join the meetings, given their role as an independent champion for local residents with regard to health and social care. The inclusive and partnership wide membership of our Board and wider governance structures will support the ICB and ICS to deliver on our aims and priorities for all of north east London's residents.

2.2 Committee development: Following the establishment of committees, the Chair, Chief Executive, Committee Chair and lead officers have been meeting to further review and refine each terms of reference, also setting out the forward plan for 2023/24. Please note the immediate proposed changes in 3.3 below to the Quality, Safety and Improvement Committee membership as discussed at the Board development session.

Each of the seven place sub-committees have held or are holding their inaugural meetings this month to agree their terms of reference, which have been developed in partnership over the past year. Preparation for the first provider collaborative committees is underway.

Local government nominees to the system Executive Committee, which includes executive leaders from ICS partner organisations, have been agreed. The Committee includes two local authority chief executives, along with lead directors from adult social care, children's care and public health.

3.0 Board development

3.1 Development session: The Board held a first development session on 20 July with a focus on introductions and collective understanding as a recently established Board. The session included a productive discussion on ways of operating and the role of the Board – individually and together.

3.2 Principles for decision making: Colleagues discussed their aspirations and expectations for how the Board should work together, and what principles should guide decision making. The outcome of the session has been developed into a long-list of principles set out in Appendix 1 for discussion today, with a view to reducing these to a maximum of six. Following comments, the Chair and Director of Corporate Affairs will finalise a set for inclusion in the updated Governance Handbook, due to come to the next meeting of this Board.

3.3 Follow up to 1 July Board meeting: Issues raised at the inaugural board meeting regarding financial delegation and the quality, safety and improvement (QSI) committee were addressed in the development session. The first of these was regarding financial delegation and sign-off limits, to ensure they are appropriate to seniority. The wording was adjusted in the standing financial instructions to reflect this and will be formally agreed at this meeting and included:

- Ensuring that the Standing Financial Instructions (SFIs) are clear on the need for staff to undertake assurance processes for expenditure – including more than one person reviewing spend (section 1.1)
- Additional information for budget holders to be clear on the responsibilities of authorising expenditure and importance of more than one reviewer (section 4)
- Within the Scheme of Reservation and Delegation (SoRD) changing 'unlimited' to 'unlimited within budget'
- Amending 'unlimited within budget' for the Chief Executive (CE) and Chief Finance and Performance Officer (CFPO) to joint authorisation only.

In addition, there was discussion regarding the ICB's quality, safety and improvement committee in terms of streamlining the membership, given the wider system committee has a broad and inclusive membership. The committee's membership now consists of the following:

- Non-Executive Member (Chair)
- Non-Executive Member (Vice Chair)
- Associate Non-Executive Member
- Chief Nursing Officer
- Chief Medical Officer
- Chief Participation and Place Officer or their nominated deputy

4.0 Integrated Care Partnership - North East London Health and Care Partnership and Steering Group

4.1 Each integrated care system (ICS) must establish an integrated care partnership (ICP) comprised of all local authorities, the integrated care board (ICB) and local health and care partners. Following extensive discussions in north east London over the past 18 months it was agreed that given the size and complexity of our system, plus the

commitment to a wide and inclusive partnership, that we would establish a smaller steering group to 'guide' the work of the partnership.

4.2 The inaugural meeting of the steering group took place on 8 September, with nominees from local government (Cabinet Members from Newham and Redbridge plus a public health director), along with voluntary sector (Tower Hamlets) and Healthwatch (Barking and Dagenham, and Waltham Forest), plus mental health and acute collaborative nominees. The group focused on its purpose, that of the wider partnership and development of the ICP's integrated care strategy given the guidance has now been issued from NHS England. The group will meet more frequently initially given the timeline for the strategy development.

4.3 The broader partnership will operate in workshop format to ensure effective contributions to the overall health and care strategy in north east London in line with our collective purpose, four priorities and design principles. A series of workshops is being planned for autumn to support development of the strategy which is due later this year.

5.0 Conclusion

5.1 We are operating as a new organisation and reshaped system in a complex landscape with responsibility for the health and wellbeing outcomes of a diverse population of approximately two million people. We have made good progress in establishing the governance for our system and in devising the underpinning architecture of how we will work. We fully recognise that this framework alone will not achieve the outcomes we are aiming to deliver, these will rely on all partners to work to common purpose over the coming months and years.

Appendix 1 - DRAFT for Board discussion

NB: the principles numbered below are a long-list to enable discussion, and will be edited to create a shorter list of six maximum.

Our Approach to Governance

Together, as the Board of NHS North East London, we have developed a framework and guide for how we will individually and collectively approach our responsibilities, to ensure that we proactively reflect the values and purpose of NHS North East London and our wider North East London Health and Care Partnership.

This framework provides clarity for our staff, partners, people and communities on the principles of decision making we have committed to, and by which we will hold each other responsible and for which ultimately the public will hold us to account.

We recognise and understand that as the Board, we are mutually accountable for and have a collective endeavour to ensure the system achieves the aims of an ICS, which are to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

In line with our locally agreed **purpose**:

"We will work with and for all the people of North East London to create meaningful improvements in health, wellbeing and equity."

Through our approach we will:	**To deliver on our system priorities:**
Improve quality and outcomes	Employment and workforce
Secure greater equity	Children and young people
Create value	Mental health
Deepen collaboration	Long term conditions

Our approach to governance will ensure that our decisions are grounded in the following principles of decision making. We will:

1. Always put the best interests of all the residents of north east London first
2. Proactively tackle health inequities in access, experience and outcomes
3. Bring our experience and sector perspective, rather than representing the individual interests of any member organisation or place over those of another.
4. Demonstrably consider the equality, diversity and inclusion implications of the decisions we make
5. Provide constructive challenge but always remain 'solution-focused'
6. Be open and transparent, including when we have challenges, and ensure our communities can hold us to account for delivery
7. Have a relentless aspiration for improvement
8. Create a culture of creativity, innovation and inspiration, enabling transformation for better outcomes with our people and communities

9. Be brave and ambitious for our communities, while ensuring we are grounded and realistic
10. Consider risks and mitigations carefully, but not be risk averse where we believe we can make improvements for local people
11. Establish a culture where our residents are our partners and co-production is universally applied
12. Support distributed leadership and decision making – close to people – being outcome focused whilst assuring performance.
13. Demonstrate and enable collaboration, mutual accountability, shared learning, embedding of best practice and joint development.
14. Secure the best value and benefit from our collective resources, maximising productivity.
15. Abide by the standards set out in our Code of Conduct statement within the Governance Handbook *(NB hyperlink will be added once approved by Board and published)*

North East London
Integrated Care Board

NHS North East London ICB Board

28 September 2022

Title of report	Risk management update
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery, Chief Participation and Place Officer
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Executive summary	The paper outlines progress to date, the proposed approach for risk management in the ICB and initial views on the system risks to meeting the four ICS aims, our purpose and priorities, for wider Board discussion and consideration. Discussions to date are informing where together system partners agree the ICB and our wider partnership can have the most impact in terms of addressing system risks. There is a common perspective that it is those risks that cross organisational boundaries and/or those that require the support and input of one or more partners where we can add value and should focus. In terms of policy and process within the ICB, there has been a positive internal audit review of risk arrangements reported to the September Audit and Risk Committee. Following the Board's discussion today, the register and board assurance framework (BAF) will be fully populated for consideration in the next development session and formally at the next Board meeting in November.
Action required	To consider the outcomes of partner discussions on system risk, discuss the Board's perspective regarding these and advise to inform the development of the BAF for the subsequent development session and next Board meeting.
Previous reporting	N/A
Next steps/ onward reporting	• Audit and Risk Committee for assurance on any further development of ICB risk management strategy and policy, and to consider the proposed BAF – October 2022 • Executive Management Team to review the corporate risk register in October 2022. • Board development session in October 2022

	• Board to review proposed board assurance framework (BAF) in November 2022.
Conflicts of interest	N/A
Strategic fit	Implementing the risk strategy and policy for the ICB will support achievement of the ICB's corporate objectives through managing risks to delivery.
Impact on local people, health inequalities and sustainability	The paper sets out how we plan to establish risk management within the ICB and system in order to achieve our aims for our population.
Impact on finance, performance and quality	Relates to achievement of our corporate objectives on these matters.
Risks	This report relates specifically to risk. The key risk in relation to this process is ensuring that we retain high levels of delegation but ensure a joined-up approach to ensure proper management and oversight of risk both locally and NEL wide.

Risk Management Update

1.0 Background

1.1 Introduction

At the inaugural meeting of NHS North East London on 1 July, the Board approved the ICB's risk management policy and strategy. The Executive Management Team (EMT) has begun work on the corporate risk register which in turn will inform the board assurance framework (BAF), building on the legacy risk register inherited from the former North East London Clinical Commissioning Group (NEL CCG).

Fundamental to our approach is a focus as a Board on system risks and how together as partners we collectively identify and mitigate these. In a system as complex as an integrated care system, and particularly one as large as north east London, there will inevitably be a large number of lenses through which we can view risk, and many institutions and partnerships holding risk in different ways.

The following brief paper outlines progress to date in implementing the ICB risk management policy and strategy, in identifying and shaping our system risks and in understanding how we work together as partners to mitigate these.

1.2 ICB risk management policy and strategy

Prior to the establishment of NHS North East London, the new organisation's risk management policy and strategy was developed by the governance team with internal auditors RSM and socialised with key stakeholders across north east London, including place based partnerships leads.

The policy was further updated following the first meeting of the Board to include the aims of the Integrated Care System:

- To improve outcomes in population health and healthcare
- To tackle inequalities in outcomes, experience and access
- To enhance productivity and value for money
- To support broader social and economic development

As the ICB and system develops over the year, a full set of strategic objectives will be established and in place for April 2023. Our key focus in terms of managing risk is identifying together what the risks are that could impact on our achievement of the four aims and what we will do together to mitigate these. Central to this is our system agreed **purpose**: *"We will work with and for all the people of North East London to create meaningful improvements in health, wellbeing and equity."*

In line with these principles:	**Ensuring we focus on these priorities:**
Improve quality and outcomes	Employment and workforce
Secure greater equity	Children and young people
Create value	Mental health
Deepen collaboration	Long term conditions

Legacy risks from NEL CCG have been collated and shared with each chief officer to ensure that ongoing risks are managed, and to ensure that each is considered as the new department registers are developed.

The ICB Audit and Risk Committee on 21 September will receive an internal audit report on due diligence and risk management which achieved substantial assurance following a recent review. Our auditors were assured that the risk management policy and strategy in place would ensure safe transition of risk from the CCG to the ICB. Implementing this is our priority. The committee will also receive an update on implementation in line with the policy and process agreed on 1 July.

1.3 ICB and system partners working together

1.3.1 **NHS non-executive leaders:** on 15 September NHS Trust Chairs and ICB non-executives discussed their views on what the overall system risks are, beyond those within individual organisations, to achieving our four ICS objectives. The Chair's report also updates the Board on the outcome of these discussions.

1.3.2 **NHS governance colleagues:** through a system working group are exploring how to better align risk management and reporting. As a first step the ICB has procured the risk management system common to our providers. Each statutory organisation remains accountable for their own risks, but increasingly and given the degree of interdependency and common purpose, we will adopt a more consistent approach. Plans to extend the group to local government governance leads is underway.

1.3.3 **Risk Champions**: as part of the implementation process of the new policy, each chief officer has nominated a risk champion. The champions will not hold responsibility or accountability for the risks, but will support their chief officer with whom the responsibility lies. The role of the risk champions is to help embed a culture of effective risk management– within their departments and with partner colleagues.

2.0 System and strategic risks

2.1 We recognise that each part of the system has its own arrangements for managing and mitigating risks, with associated and well-established governance processes for assuring this, which include for instance Trust Board governance, Adults and Children's Safeguarding Assurance Boards and Partnerships and Scrutiny functions. Notwithstanding this, there is a growing understanding of the role of the ICB Board in relation to system risk, which it is suggested is to:

1. Focus on risks which stretch across the whole system and therefore cannot be managed by individual institutions
2. Focus on risks in one part of the system which may have significant implications for other partners, where there is no other governance or partnership route to address these

There have been initial discussions about some of the key system risks for north east London which include:

- Financial
  - Insufficient funding to achieve our core outcomes
  - Lack of parity in capital and revenue funding
  - Funding tied in to specific initiatives in the long-term

- Reputational
  - Lack of trust and confidence including from our local residents – impacting on prevention e.g. take up of immunisations

    - Clarity over our role in relation to our local population and as part of regional and national system response
    - Reputation, as stated above impacts on a range of factors including access, to the extent that the core delivery of our plans is affected

- Economic and political
    - Significant shift in direction of national policy and legislation
    - Risk of being a conduit for nationally determined issues and lose ability to maintain focus on our priorities and way of working so that national priorities overcome
    - Inflation, energy increases
    - Environmental sustainability
    - Variation across north east London due to health and wider inequalities
    - Lack of local employment mechanisms with missed opportunities for improvement in health and wellbeing outcomes

- Clinical and quality – in so far as they can be separated from operational risks and pressures
    - Lack of a shared approach to culture and risk
    - Lack of a shared learning and transparent culture

- Operational risks – that are so significant has to have widespread impact including provider/partner failure and workforce
    - Not being able to recruit with no pipeline for critical roles
    - Lack of wage competitiveness in the labour market
    - Staff wellbeing and morale

- Pressures within one part of the system – that have significant knock-on impacts to other parts of the system if not mitigated, wherever and however these have been generated

3.0 Next steps

3.1 EMT will review the corporate risk register based on the discussions to date and at this Board meeting, and develop a proposed board assurance framework for consideration at the October Audit and Risk Committee and Board development session, before coming to the next board meeting in November 2022.

3.2 The discussion at the Board will lead to a wider understanding and appreciation of the system risks and our role which will be captured in our strategic and system risk register for the ICS.