NHS North East London Integrated Care Board

25 January 2023, 1.30pm – 4.00pm Waltham Forest Town Hall Campus, May Suite, 1st Floor, Forest Road, E17 4JF – hybrid meeting

	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 30 November 2022			Attached	Approve
1.3	Action log			Attached	Note
2.0	**Resident story**	1.35		Verbal	Discuss/ note
3.0	**Chair and chief executive officer reports**				
3.1	Chair's report	1.55	Chair	Attached	Note
3.2	Chief executive officer's report	2.00	ZE	Attached	Note
4.0	**Strategy**				
4.1	Integrated care strategy	2.05	JM	Attached	Adopt
4.2	Joint forward plan - update	2.15	JM	Attached	Note
4.3	Deep dive into primary care	2.25	JM	Attached	Note
5.0	**Board assurance**				
5.1	Board assurance framework	2.40	CP	Attached	Note
6.0	**Finance and performance**	2.50	HB	Attached	Note/ approve
6.1	Month 8 2022-23 Finance overview and Month 7 Performance overview				
7.0	**Governance – reports for noting**				
7.1	Executive committee exception report	3.00	ZE	Attached	Note
7.2	Audit and risk committee exception report	3.05	SE	Attached	Note
7.3	Workforce and remuneration committee exception report	3.10	DH	Attached	Note
7.4	Quality, safety and improvement committee	3.15	IR	Attached	Note
7.5	Finance, performance and investment committee exception report	3.20	HB	Attached	Note
7.6	Population health and integration committee exception report	3.25	Chair	Attached	Note
8.0	**Board forward plan**	3.30	Chair	Attached	Note
9.0	**Questions from the public**	3.35	Chair	Verbal	Discuss
10.0	**Any other business and close**	3.50	Chair	Verbal	Discuss
Date of next meeting: 29 March 2023					

Purpose, priorities, aims and our decision-making principles

Our agreed ambition, which is also that of North East London Health and Care Partnership which we are part of, is that "**We will work with and for all the people of north east London to create meaningful improvements in health, wellbeing and equity**".

To help guide our work, together partners have agreed **four priorities, or joint action areas,** where we want to create measurable change, which will create key outcomes for our system and place strategies. These are:

1. **Employment and workforce** – to work together to create meaningful work opportunities and employment for people in north east London now and in the future.
2. **Long term conditions** – to support everyone living with a long-term condition in north east London to live a longer, healthier life and to work to prevent conditions occurring for other members of our community.
3. **Children and young people** – to make north east London the best place to grow up, through early support when it is needed and the delivery of accessible and responsive services.
4. **Mental health** – to transform accessibility to, experience of and outcomes from mental health services and well-being support for the people of north east London.

Partners also agreed the following design or operating principles for our system:

Improving quality and outcomes: Individually and together, we will continuously improve access, experience and outcomes for and with our residents, with a specific focus on delivering integrated care in the neighbourhoods where our residents live and work. We will seek to learn together and from international best practice to continuously improve quality, to reinvent our ways of working and better secure our outcomes.

Securing greater equity: We will resolutely tackle inequality in outcomes and experience for our residents and staff, harnessing the diversity of our north east London experience to create better and more responsive solutions and utilising our combined resources to tackle the causes of inequality. We embrace the right of our residents to meaningfully participate, as an equal part of our team, benefiting from the strengths that they bring as individuals and communities.

Creating value: We will transparently work with our residents and staff to secure the maximum, sustainable benefit from our physical, digital and financial resources, repurposing what we have, reducing waste and taking care of our environment. Critically we will support and enable our most important resource, our staff, to reach their potential, enjoy work and be able to effectively contribute to our vision.

Deepening collaboration: We will work in meaningful partnership towards shared goals, holding each other to account for the commitments we have made to each other and to our residents. We will set resident interest and the common good as our

defining success measure and we will support our staff to lead and deliver across organisational boundaries. Our key collaboration will be with our residents, who will drive and co-deliver and evaluate the outcomes of our partnership

The four aims of our 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

Our decision-making principles

ICB board members have agreed a set of principles for decision making as follows:

- Always put the best interests of all the residents of north east London first within a culture where our residents are our partners and co- production is universally applied
- Proactively tackle health inequities in access, experience and outcomes. Demonstrably consider the equality, diversity and inclusion implications of the decisions we make
- Bring our experience and sector perspective, rather than representing the individual interests of any member organisation or place over those of another.
- Be open and transparent, including when we have challenges, and ensure our communities can hold us to account for delivery. Though this provide constructive challenge, but always remain 'solution-focused'
- Create a culture of creativity, innovation, improvement and inspiration, enabling transformation for better outcomes with our people and communities
- Be brave and ambitious for our communities, while ensuring we are grounded and realistic. In doing this consider risks and mitigations carefully, but not be risk averse where we believe we can make improvements for local people
- Support distributed leadership and decision making – close to people – being outcome focused whilst assuring performance.
- Demonstrate and enable collaboration, mutual accountability, shared learning, embedding of best practice and joint development.
- Secure the best value and benefit from our collective resources, maximising productivity.

North East London Integrated Care Board Register of Interests

- Declared Interests as at 11/01/2023

Name	Position/Relationship with 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	ICB Board ICB Workforce & Remuneration Committee ICS Executive Committee	Financial Interest	London Borough of Havering	Employed as Chief Executive	2021-05-01		Declarations to be made at the beginning of meetings
Diane Herbert	Non Executive Member	ICB Board ICB Workforce & Remuneration Committee	Non-Financial Professional Interest	Hertfordshire Partnership University Foundation Trust (HPFT)	Non executive director	2019-05-19		
Diane Jones	Chief Nurse	ICB Board ICB Quality, Safety & Improvement Committee ICS Executive Committee Primary care contracts sub-committee	Non-Financial Professional Interest	Royal College of Nursing (RCN)	Professional membership	2020-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of Midwives (RCM)	Professional membership	1994-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Nursing & Midwifery Council (NMC)	Professional membership	1992-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Clinical Senate	Member	2017-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Homerton Hospital	Midwife (honorary contract)	2015-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Group B Strep Support (GBSS)	Director and Trustee	2020-01-01		Declarations to be made at the beginning of meetings
Dr Mark Rickets	ICB Primary Care Partner Member AND Clinical Lead for Primary Care	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Workforce & Remuneration Committee ICS Executive Committee Primary care contracts sub-committee	Financial Interest	Nightingale Practice	Salaried GP	2022-02-02		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	GP Confederation	Nightingale Practice is a member	2022-02-02		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	2022-02-02		Declarations to be made at the beginning of meetings
			Financial Interest	Homerton University Hospital NHS Foundation Trust	Non-executive Director	2022-02-02		Declarations to be made at the beginning of meetings
			Indirect Interest	Point of Care Foundation	My wife is an Associate with the Point of Care Foundation whose work includes being a mentor for NEL ICS Schwartz Rounds	2022-03-01		Declarations to be made at the beginning of meetings

Dr Paul Francis Gilluley	Chief Medical Officer	ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Primary care contracts sub-committee	Non-Financial Professional Interest	British Medical Association	I am a member of the organisation.	2022-07-01		
			Non-Financial Professional Interest	Royal College of Psychiatrists	Fellow of the College	2022-07-01		
			Non-Financial Professional Interest	Medical Defence Union	Member	2022-07-01		
			Non-Financial Professional Interest	General Medical Council	Member	2022-07-01		
			Non-Financial Personal Interest	Stonewall	Member	2022-07-01		
Henry Black	Chief Finance and Performance Officer	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee ICS Executive Committee	Indirect Interest	BHRUT	Wife is Assistant Director of Finance	2018-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Tower Hamlets GP Care Group	Daughter is Social Prescriber	2020-01-01		Declarations to be made at the beginning of meetings
Jagan John	Primary Care Board representative	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICS Executive Committee	Financial Interest	Parkstone Holdings Ltd	Director	2020-02-02		Declarations to be made at the beginning of meetings
			Financial Interest	Aurora Medcare (previously known as King Edward Medical Group)	GP Partner	2020-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Parkview Medical Centre	GP Partner	2020-05-01		Declarations to be made at the beginning of meetings
			Financial Interest	Together First Limited (GP Federation)	Practice is a shareholder	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Harley Fitzrovia Health Limited	Director and Shareholder	2018-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Diagnostics 4u (previously Monifieth Ltd)	Director and Shareholder	2020-10-01		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	2020-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	New West Primary Care Network	Brother / GP Partner is the Clinical Director	2020-11-01		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	2017-05-01		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	2011-08-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barking and Dagenham Health and Wellbeing Board	Deputy Chair	2018-01-01	2022-06-30	Declarations to be made at the beginning of meetings
			Financial Interest	Buxton Medica	GP partner is director and practice is share holder	2021-10-31		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	2022-09-01		Declarations to be made at the beginning of meetings

Johanna Moss	Chief strategy and transformation officer	ICB Board ICB Population, Health & Integration Committee ICP Committee ICS Executive Committee Primary care contracts sub- committee	Non-Financial Professional Interest	UCL Global Business School for Health	Health Executive in Residence	2022-09-01		Declarations to be made at the beginning of meetings
Marie Gabriel	ICB and ICP Chair	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICB Workforce & Remuneration Committee ICP Committee	Non-Financial Personal Interest	West Ham United Foundation Trust	Trustee	2020-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	East London Business Alliance	Trustee	2020-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Race and Health Observatory	Chair of the RHO	2020-07-23		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Member of the labour party	Member of the labour party	2020-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Confederation	Trustee Associated with my Chair role with the RHO	2020-07-23		Declarations to be made at the beginning of meetings
			Financial Interest	Local Government Association	Peer Reviewer	2021-12-16		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	UKHSA	Associate NED	2022-04-25		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	2022-03-13		Declarations to be made at the beginning of meetings
Marie Price	Director of Corporate Affairs	ICB Audit and Risk Committee ICB Board ICP Committee	Indirect Interest	Greater London Authority	Partner works as NE London region regeneration lead	2017-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Lower Clapton GP Practice, Hackney	Registered as a patient at a GP practice in NEL. Lower Clapton GP Practice, Hackney	2008-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Cadence Partners	Close friends with managing partner and head of operations. Cadence Partners is an executive search firm.	2018-12-03		Declarations to be made at the beginning of meetings
			Indirect Interest	Hackney Council	Close friend with Strategic Director Engagement, Culture and OD (also responsible for communications)	2020-01-01		Declarations to be made at the beginning of meetings
Paul Calaminus	Chief Executive	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICB Board ICS Executive Committee	Non-Financial Professional Interest	East London NHS Foundation Trust	Chief Executive	2021-04-30		Declarations to be made at the beginning of meetings
			Indirect Interest	Department of Health	Partner is employed by Department of Health	2021-04-30		

Philip Glanville	Local authority rep on ICB Board	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICB Board ICB Finance, Performance & Investment Committee	Financial Interest	London Borough of Hackney	Mayor of Hackney	2016-09-19		
			Financial Interest	London Councils				
			Financial Interest	Local Government Association (LGA)				
			Non-Financial Professional Interest	London Legacy Development Corporation (LLDC)				
			Non-Financial Professional Interest	London Office of Technology and Innovation				
			Non-Financial Professional Interest	Central London Forward				
			Non-Financial Professional Interest	Growth Borough Partnership				
			Non-Financial Professional Interest	Greater London Authority (GLA)				
			Non-Financial Professional Interest	London Councils				
			Non-Financial Professional Interest	London Councils				
			Non-Financial Personal Interest	East London Foundation Trust				
			Non-Financial Personal Interest	Unison				
			Non-Financial Personal Interest	Unite the Union				
Sue Evans	Associate Non Executive Member and Interim Audit Chair	ICB Audit and Risk Committee ICB Board	Non-Financial Professional Interest	Worshipful Company of Glass Sellers' of London (City Livery Company) Charity Fund	Company Secretary / Clerk to the Trustees'	2014-01-01		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	2017-01-01		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	2013-01-01		Declarations to be made at the beginning of meetings
Will Tuckley	Member of a committee, sub committee and/or attendee at these and other bodies	ICB Board ICB Workforce & Remuneration Committee ICS Executive Committee Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Non-Financial Professional Interest	L B Tower Hamlets	I am the Chief Executive of LB Tower Hamlets. Decisions that benefit the Borough may be seen to add to my success in leading the organisation and the place.	2015-10-15		Declarations to be made at the beginning of meetings
Zina Etheridge	Chief Executive Officer Designate of the Integrated Care Board for north east London	ICB Audit and Risk Committee ICB Board ICB Population, Health & Integration 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 at Royal Berkshire hospital	2022-03-17		Declarations to be made at the beginning of meetings

- Nil Interests Declared as of 11/01/2023

Name	Position/Relationship with ICB	Committees	Declared Interest
Francesca Okosi	Chief People and Culture Officer	ICB Board ICB Workforce & Remuneration Committee ICS Executive Committee	Indicated No Conflicts To Declare.
Charlotte Pomery	Chief Participation and Place Officer	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 ICB Board ICB Population, Health & Integration Committee ICP Committee ICS Executive Committee Newham Health and Care Partnership Newham ICB Sub-committee Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee	Indicated No Conflicts To Declare.
Maureen Worby	Councillor In London Borough of Barking & Dagenham	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee	Indicated No Conflicts To Declare.
Caroline Rouse	Member of IC Board (VCS rep)	ICB Board ICP Committee	Indicated No Conflicts To Declare.
Shane DeGaris	ICB member	ICB Board ICS Executive Committee	Indicated No Conflicts To Declare.
Imelda Redmond	Non-executive member	ICB Audit and Risk Committee ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee	Indicated No Conflicts To Declare.
Cha Patel	Non-executive member	ICB Board Audit & Risk Committee Chair	In progress
Manisha Modhvadia	Healthwatch	OCB board	In progress

NHS
North East London
Integrated Care Board

Draft minutes – NHS North East London ICB board

30 November 2022 - 1.30pm – 4.05pm, Council Chamber, Barking Town Hall

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 (via MS Teams at 2.00pm)
Cllr Maureen Worby (MW)	Local authority partner member
Caroline Rouse (CR)	CVSE 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 Rickets (MR)	Primary care partner member (from 2pm)
Dr Jagan John (JJ)	Primary care partner member
Diane Herbert (DH)	Non-executive member, NHS North East London
Imelda Redmond (IR)	Non-executive member, NHS North East London
Sue Evans (SE)	Interim non-executive member, NHS North East London
Attendees:	
Manisha Modhvadia (MM)	Healthwatch participant
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
Johanna Moss (JM)	Chief strategy and transformation 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:	
Mayor Philip Glanville (PG)	Local authority partner member
Will Tuckley (WT)	Local authority executive participant

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting including Manisha Modhvadia, Healthwatch participant and Johanna Moss, Chief strategy and transformation officer who were attending the formal board meeting for the first time. The Chair also welcomed members of the public who had joined the hybrid meeting to observe either in person or via the MS Teams virtual link. The Chair advised people of the fire alarm procedure and other housekeeping matters before proceeding.

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.
1.2	**Minutes of the last meeting**
	The minutes of the meeting held on 28 September 2022 were agreed as a correct record.
1.3	**Matters arising**
	The ICB board noted the update on the September resident story and the action being taken by the ICB. The two key points were: • The resident story reinforced the importance of the work we do with carers and informal carers including those within our own workforce. • Carers are likely to be our largest unpaid workforce and we need to include support for carers as part of the development of our workforce plans going forward. A progress report on the resident stories will come to the Board in March 2023. **ACTION: CP**
1.4	**Action log**
	The ICB board noted the action taken since the last meeting. The Chair asked for the target dates action 7.0 relating to 'non' constitutional performance to be reviewed as the discussions are ongoing. **Action: HB** The updated governance principles were circulated at the meeting and will be part of each board pack going forward along with our purpose and design principles. **Action: CP**
2.0	**Resident story**
	The board listened to an audio recording from a care co-ordinator based in a Primary Care Network (PCN) in Barking and Dagenham. He talked about his employment journey into the health and care sector following an accident that had resulted in him being unable to continue his work as an engineer. Following a role as a security guard and finding out more about health and care through a role with a vaccination centre, he joined a practice as a receptionist and then progressed into a social prescribing and as a care co-ordinator. He spoke with enthusiasm and explained how each new role has given him job satisfaction and fulfilment, knowing that he is helping people in the community. Discussion points included: • How the shared experience is an inspiration and we could consider how it could be used to inspire others. • The huge opportunities there are for employing local residents in health and social care and the need to maximise the opportunities by finding new ways in which we can promote employment opportunities to our residents.

	• The need to be focussed on career development and retention and to regularly ask our workforce what they want to do and how they would like to progress. • The important role of the voluntary sector in supporting local people into employment and as employers. • The importance of seeing the 'whole person' and considering all staff including sub contracted staff • The need to focus on our ICB role and that of ICS member organisations as Anchor institutions. The Chair expressed her thanks for the care co-ordinator for sharing his experience of working in the health and care sector and for explaining how his role is enabling him to live a fulfilling life and making such a positive contribution to the local community. The Chair added that the story is relevant to the Workforce Strategy item later on the agenda and will feed into the strategy.
3.0	**Chair and chief executive reports**
	3.1 Chair's report The Chair presented her report to inform the Board of the key points arising from NEL Integrated Care System, (ICS) Non-Executive meetings to ensure their views are taken in to account in board decision making. The report also provided an update on the most significant activities undertaken by the Chair and Non-Executives since the last Board meeting. The following key areas in the report were highlighted: • The Integrated Care Partnership (ICP) – the first formal meeting was held on 23 November and members considered the ongoing development of our ICP led system integrated care strategy including the key emerging themes following a series of workshops: o Co-production with residents, drawing on individual and community strengths and assets, rebalancing power. o Greater focus on prevention across all parts of our system including primary prevention and wider determinants. o Holistic and personalised care that is integrated seamlessly across service or organisational boundaries. o A high trust environment supporting partnership working, collaboration and integration across all parts of our system, with the contribution all partners valued equally. o Working as a learning health system to drive continuous development, improvement and shared learning. o A relentless focus on equity underpinning all that we do. • The two visits to North East London by the Chair of NHS England, Richard Meddings. Themes included the need for a meaningful focus on staff morale including capacity, to improve national clinical recruitment processes, to consider the interface between primary and community care, to explore the use of digital and to tackle inequalities and to focus on the wider determinants of health, particularly housing. The Chair thanked the team the team at Woodgrange Practice and the frontline staff from, across our Trusts and primary care for their openness in sharing their experiences with Richard. • The Chair also highlighted that she had been invited to speak to the Newham GP Federation in regard to what is meant by clinical leadership. The Chair suggested it would be helpful to have clinical leadership as an item for discussion at either the January or March board meeting and

	advised that Dr Tamara Hibbert had agreed to present as part of this item. **ACTION: PG.** • Health Education England (HEE) - presented its draft 'Framework 15' at the London People Board. The aim of the Framework is to ensure that there is a reference point for the national health and care system so that it understands how HEE will approach workforce planning and will provide a structure for decision making for both annual and longer-term workforce plans. FO clarified that the work being undertaken by HEE is at an ICS level and we will look at the wider remit and incorporate that into the Workforce Strategy. • NEL Trust Chairs and ICB Non-Executive members received presentations on the ICS approach to workforce and our ICB financial Strategy and their comments will be incorporated in Board contributions as the items are discussed within the agenda. The ICB board noted the report. **3.2 Chief executive's report** ZE presented her report which covered the following areas: • Preparing for winter – the system is working collaboratively to do all we can to keep our residents safe and well. • Financial recovery summit. • System visits – including primary care sites in Barking and Dagenham and an overview of some of the new initiatives underway such as the 'winter coat collection' demonstrating the added support primary care is providing. • Health Service Journal (HSJ) top 50 – congratulations were conveyed to our chair Marie Gabriel on being listed in the HSJ's annual list of the 100 most influential people in health and in the 50 most influential Black, Asian and minority ethnic leaders alongside Tanya Carter, chief people officer at East London Foundation Trust. Both of whom have been recognised by the HSJ for their contributions to the NHS. • Diabetes award - congratulations were conveyed to everyone involved. • NHS safeguarding award – congratulations were conveyed to Eve McGrath from the NHS North East London team on winning an safeguarding award in recognition of her dedication to ensuring the strategic priorities of the adult safeguarding agenda were maintained in Barking and Dagenham, Havering and Redbridge at a time when those areas were experiencing challenges with resources. • The Fuller Event workshop - held on 29 November to launch the north east London implementation for the Fuller review. Dr Claire Fuller focussed on a number of key themes and reiterated how important primary care is in providing continuity of care, as well as urgent care. As part of the discussion, MM advised that Healthwatch has been commissioned to work with the London Ambulance Service. The work is due to be completed by the end of January 2023 and the results will be shared locally. The Chair added congratulations for winners of the annual HSJ Awards, each of which illustrated our collaboration. These were for Workforce Initiative of the Year, Collaboration of the Year and Place Based Partnership of the Year awards. The ICB board noted the report.
4.0	**Board assurance**

4.1 Board assurance framework

CP presented the report which outlined progress made to date on the draft Board Assurance Framework (BAF) which captures the highest risks to meeting the integrated care system (ICS) aims, our purpose and four priorities.

The key points were:

- The BAF has been further developed following a series of discussions including the discussion at the September board meeting and the board development session in October, along with executive, committee and wider partnership sessions. It will be a standing agenda item.
- Current key risks on the BAF relate to:
    - Ownership of ICP integrated care strategy
    - Air quality
    - Health inequalities
    - Collaborative working across partners
    - Delivery against control total and operating plan
    - Resourcing of ICB and ICS structures
    - Population growth

Key discussion points:

- Members acknowledged the huge amount of work involved in getting the BAF to this position, noting that it is work in progress and needs to reflect the whole system.
- MW advised that local authority chief executives will be reviewing the BAF to ensure it reflects local authority risks and issues including shared risks; cost of living crisis; air quality; population growth.
- Members agreed that some of the narrative needs to change. Air pollution was given as an example, noting that it is a much wider issue and the risk needs relate to the 'environment' including for example damp housing and health impacts. It was suggested that consideration needs to be given as to how we can challenge planning permission in regard to new homes being built next to dual carriageways.
- The focus is currently on adults and needs to reflect the risks and issues within children's services particularly those relating to housing issues.
- It was noted that some risks may not be positioned in the right place on the BAF and the Chair advised that is being reviewed.
- A clearer understanding of what we are trying to achieve in terms of the likelihood of a risk alongside its severity was requested and it was suggested it would be helpful to see the likelihoods. Including civil contingencies was also suggested.
- The Chair asked for our four priorities to be included on the BAF, noting that the risks need to reflect our strategic ambitions.
- The Chair also asked for a box on gaps in control/assurance and said asked that the Finance Team include productivity.
- Long term financial support for the voluntary sector was suggested as an area for consideration.

The discussion points will be taken in to account as part of the on-going development of the BAF. **ACTION: CP**

The ICB board noted the proposed Board Assurance Framework.

5.0	Strategy
	5.1 Integrated care strategy JM presented the update and highlighted the key points: • The intention is to sign off the interim strategy at a meeting of the Integrated Care Partnership in January 2023 following a period of engagement with local health and wellbeing boards, joint overview and scrutiny committees and place-based partnerships. • This strategy is being co-produced with our residents and the Strategy Task and Finish Group, chaired by ZE, has overseen a series of well attended system-wide stakeholder workshops to feed into the process and shape the strategy. The workshops during October and November focused on progressing our system priorities of babies, children and young people; mental health; long term conditions; and workforce and employment. In addition, over 120 people attended a workshop on our system response to the cost of living increase. Discussion points included: • Board members noted and welcomed the inclusive engagement process being undertaken, given the tight timelines. • The next phase of development needs to align further with Place. • There needs to be a feedback mechanism for work that is being undertaken by the voluntary sector which is not funded by the system, in order to be able to capture what has been trialled and is working. • Carers need to be included. • Some of the language needs to change in regard to use of NHS acronyms. • The strategy needs to be cross referenced with other strategies particularly our workforce strategy. • Our four priorities need to be the common thread in all our strategies. JM to take the suggestions forward. **ACTION:JM** The ICB board noted the report. **5.2 Integrated Care System workforce strategy** FO presented the update to inform the board on the progress made to date on the development of the workforce strategy. The following key points were highlighted: • We are working with system partners to transform and move to a one north east London workforce that can work across the health and care system. • The update is based on key themes and actions that came out of the workforce strategy workshop held on 1 November 2022. • The growing population that we have within north east London is a positive opportunity that we are building on by working collaboratively with local schools, colleges, universities and other organisations across the system to create meaningful employment for all our residents. • Disparity of pay (including inner vs outer London rates) is one of the things that is being looked at in order to address some of the recruitment and retention challenges. • Further engagement will take place between now and March 2023 with our staff, our local communities, stakeholder groups, including primary care, local Government, voluntary sector colleagues, the wider care sector and higher education institutions. The key discussion points were:

	• The huge opportunity this provides us with to combine our strengths to get our local community into employment within health and social care. • The need to fully engage with local schools and colleges – the importance of this was emphasised. • The need for the strategy to clearly reflect career progression. • The need to explore our role as Anchor organisations. • The need to think of our workforce as a population group. • The need to have a flexible approach that enables carers to return to employment with hours that suit their caring responsibilities and enables volunteers to consider employment within the health and care sector. • How a pan-London approach is needed for some elements. • The need to include joint commitment made at the London Health Board for all health and care employers to work towards the London living wage. There was recognition of the challenge of inner and outer London weighting. • The need to consider having shared training across health and social care. • The positive impact of changing the narrative from BAME to global majority. • The need to address the retention challenge and explore the psychological contract with staff with a focus on wellbeing and ensuing work was a positive experience. • There was a need for a reflection on what it means for an integrated workforce that can provide integrated care. • The need to consider what we can do collectively to leverage around apprenticeships, anchor roles and new roles within the workplace. FO to take the suggestions forward as part of the on-going development of the strategy. **ACTION:FO** The ICB board noted the update.
6.0	**Finance and performance overview**
	HB presented the report which outlined the year-to-date financial position for the ICS and the ICB and included the August performance position, outlining key issues across a number of areas including urgent and emergency care. An update on the Better Care Fund (BCF) was also included with a recommendation to the board for approval of the 2022/23 borough BCF Section 75 arrangements and approve the delegation of the authority to sign a Section 75 agreement with the London Borough of Waltham Forest that will contain the BCF Plan and BCF Financial Schedules for 2022/23 to the Waltham Forest Place Based Sub-Committee. The key points highlighted from the finance section of the report were: • The financial position at month 7 continues to be challenging with a £57m deficit. • The key issues causing the financial pressures are; inflation, particularly the cost of utilities which is a huge issue for providers; payroll costs including high agency spend; delivery of efficiency programmes and cost improvements plans; elective recovery within planned care. • We are still forecasting a break-even position at the end of the year in accordance with national guidance. • The recent financial recovery summit held in October – commitment to a formal recovery plan was agreed. Resources are in place to oversee the work.

	Discussion points included: • The BCF arrangements – HB clarified that there are variable arrangements between each borough but there is consistency in regard to the mandatory sections of the agreements. • The huge financial pressures that the system is facing and the need for the system to find sustainable solutions was recognised. • The positive work undertaken by BHRUT to reduce agency rates that could be shared. • Cost Improvement Plans (CIPs) and whether a different approach is needed, with long term solutions and changing our approach to delivery. HB confirmed there is an opportunity now to look at whole system pathways and agreed to expand of that in the next report. **ACTION: HB** • Independent Sector spending – a request was made for that to be included in the report and HB agreed adding that a breakdown by borough will be included in the next report. **ACTION: HB** • It was suggested that it would be helpful to include the financial position of the whole system in the report going forward as well as our medium-term financial strategy, our decisions and the impacts on the voluntary sector. **ACTION: HB.** Board members were advised that performance section of the report is under review and that the new format will be presented at the next meeting. The performance section of the current report provided an update on the latest performance across north east London in regard to elective care, cancer, diagnostics, urgent care and mental health. The key discussion points were: • The need to have performance data by Place in order to enable the discussions to be held at Place, noting that each borough has different challenges. • The need for local authority and primary care performance to be included, noting that the level of detail that comes to the board needs to be at system level but triangulation of the data held is needed. • The need for trend data to be included. • The need to balance the data and exception reporting and to combine local intelligence was recognised. HB to consider all the discussion points in regard to future finance and performance reports and to also consider what needs to be at Place level and what needs to come to the board by way of an exception report. **ACTION: HB** The ICB board: • Noted the content of the report and the key risks to the expected year-end breakeven position. • Noted the performance report • Approved the borough BCF plans: o Approved the signing of a variation to an existing Section 75 agreement to add the BCF Plan and BCF financial schedules for 2022/23 with: o Approved the retrospective signing of a Section 75 agreement with the London Borough of Waltham Forest that will contain the BCF Plan and BCF Financial Schedules for 2021/22. o Approved the delegation of the authority to sign a Section 75 Agreement with the London Borough of Waltham Forest that will contain the BCF Plan

	and BCF Financial Schedules for 2022/23 to the Waltham Forest Place Based Sub-Committee.
7.0	**Governance**
	7.1 Executive committee exception report ZE presented the report and highlighted the following key points in the report: • Specialised services – a joint arrangement with NHS England will be put in place for all ICBs during 2023/24 with full delegation in April 2024. The joint working arrangements will allow some of the opportunities to start to be realised whilst the risks are better understood and mitigated. • Dentistry, Optometry and Pharmacy (DOPs) - commissioning responsibility for Dentistry, Optometry and Pharmacy (DOPs) will transfer from NHS England to ICBs on 1 April 2023. London ICBs have agreed the commissioning and operating model for delegated functions across London and North East London ICB will host the team. The ICB board noted the exception report. **7.2 Quality, safety and improvement (QS&I) committee exception report** IR presented the report which provided the board with an overview of the key items discussed at the October meeting of the QS&I committee and the action taken. • Looked After Children wellbeing reviews • Vaccination campaigns • Maternity • The committee approved the following documents: o Individual Funding Request policy (IFR) o Fertility policy o All age safeguarding annual reports 2021/22 o Learning Disability mortality Review (LeDeR) annual report 2021/22 o Child Death Overview Panel (CDOP) annual report 2021/22 The Chair added that we are considering how future annual reports can reflect the specific system role. The ICB board noted the exception report. **7.3 Finance, performance and investment committee exception report** HB presented the report which highlighted the following key messages: • The committee received an update on the current financial position for the ICS and the ICB and an overview of the July performance position, outlining key issues across a number of areas including urgent and emergency care. • The committee received an update following the recent financial summit and welcomed the proposal to develop a systemwide financial recovery plan and the commitment of all participants to work together to achieve required financial targets for 2022/23. However, members remained concerned about the scale of the challenges faced in achieving this objective. • The committee noted the plans being developed to determine systemwide financial allocations for 2023/34, including the setting up of an investment pool to drive innovation and transformation. • The committee approved the business case for creating a single fertility policy across north east London. • The committee approved the Primary Care Prescribing Efficiency Plan 2022/23.

	• The committee approved the standard operating procedure for operating Primary Care Rebate Schemes (PCRS). The ICB board noted the exception report. **7.4 Population health and integration committee exception report** The Chair presented the report which provided the key messages from the committee meeting held in October: • The committee received a report which provided the population health profile for north east London which supports the shift towards a population health approach for the system with clarity on the shared population health and inequalities challenges across north east London. The Committee welcomed the information and asked for the data to be used at Place Partnerships and Collaboratives to drive change. • The Committee had a detailed discussion on how we need, as a system to evolve our approach to addressing inequalities so that it is fully embedded in our work and we can evidence the change we are seeking to make. • The Committee highlighted how we should consider poverty rather than purely the current cost of living challenges and agreed that a Big Conversation with local people should take place in the Spring to further inform our work. The ICB board noted the exception report. As part of the overall discussion, HB addressed a question relating to the approval of the fertility policy referred in the QS&I committee exception report under item 7.2 and clarified that one single policy was needed for the ICB. The Chair reminded board members that they are all welcome to attend any of the ICB committees. **7.5 Governance handbook and constitution update** CP presented the update and advised that the revised governance handbook together with the committee Terms of Reference are available to view on the ICB's https://northeastlondon.icb.nhs.uk/about-the-north-east-london/our-governance/ The high-level principles for decision making that were approved by the board in September are included in handbook and the Chair confirmed the principles will be included in the meeting papers pack going forward. Thanks were conveyed to the team involved in producing the handbook and the Terms of Reference, acknowledging the huge amount of work involved. In regard to the Constitution, NHS England advised of several amendments required for all ICB constitutions which relate to points of technical detail rather than substantive matters and were detailed in the meeting papers pack as Appendix 1. The ICB board: • Approved the updated Governance Handbook • Approved the proposed amendments to the Constitution
8.0	**Board forward plan**
	The ICB board noted the forward plan and the Chair advised that discussions will be held at the local authority chief executives meeting, voluntary sector collaborative and Healthwatch collaborative about items they would like included on the forward plan. **Action: CP/MP**

9.0	**Questions from the public**
	The Chair advised that a number of questions had been received from Josh Mellor, local democracy reporter, who was in attendance and invited him to ask two of his questions. The answers to the remaining four questions will be responded to outside of the meeting due to time constraints. Josh Mellor, local democracy reporter **Question:** North east London (particularly the outer boroughs) suffer from a disproportionately low ratio of GPs and nurses compared to other parts of London, does the ICB see this as an urgent issue and what actions have the ICB's previous bodies taken and what does the ICB plan to take to address this in the short to medium term? **Answer:** JM responded advising that the data provided to her shows the ratio of GPs per 100,00 population for London is 51 which compares to an average of 59 for north east London. There is a variation between our boroughs across the system and the ICB recognises the ratio of GPs is an issue that needs to be addressed collectively as a system. In regard to the London ratio of nurses, the data shows the ratio is 15 per 100,000 population which is the same for north east London. A summary of previous action taken by the CCG to address the lower ratio of GPs was given and JM confirmed the ICB is absolutely committed to increasing the number of GPs in north east London and the target that has been agreed is at least a ratio of 44 per 100,00 in all of our neighbourhoods by 2025. **Question:** Access to face-to-face appointments and the "telephone triage" of patients by receptionists who appear not to have any medical qualifications is a widespread concern for residents, what is the ICB's policy on access to face-to-face appointments and what oversight does it have on the policy region-wide? **Answer:** Face to face appointments can be delivered in a variety of ways depending on the need, including phone, video and face-to-face. Across north east London approximately 65% of appointments are face to face and appointments are provided in the most appropriate way, depending on need. The receptionist role is not clinical, however they will try to get the patient to see the most appropriate healthcare professional within the multi-disciplinary team in the practice. There isn't a universal approach to the role of receptionist, as it will depend on each individual practice. Practices are focusing upon the multi-disciplinary role of their team but if patients are unhappy with the response they receive from the receptionist they can complain to the practice manager in the first instance. The ICB does not have an explicit role in the oversight of the role of receptionists, it is determined by GPs as independent providers and employers. The north east London training hub has developed various training support programmes which are offered to practice staff and we are keen to continue working with residents and Healthwatch to address any future concerns. A summary of questions submitted and answered by the board will be uploaded here https://northeastlondon.icb.nhs.uk/about-the-north-east-london/our-board/questions-from-members-of-the-public/
10.0	**Any other business and close**
	The Chair outlined the plan for future meetings to be held at different locations across the boroughs covered by the ICB. This will also provide an opportunity for

	board members to meeting with Place-based partnership colleagues from whichever borough the meeting is held.
	Date of next meeting – 25 January 2023

ICB board – action log

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
7.0 Finance and performance overview	**28 Sept 2022**	Discussions about considering 'non' constitutional performance together with quality to take place outside of the board meeting.	HB/ DJ	April 2023	Discussions about quality and 'non' constitutional performance reporting are underway. The aim is to have a joint report from April 2023.
1.3 Matters arising	**30 Nov 2022**	Further progress on the resident stories to be presented at the March board meeting.	CP	March 23	Added to board forward plan for March 2023.
1.4 Action log	**30 Nov 2022**	Updated governance principles to be included in the board papers going forward along with our purpose and design principles.	CP	Jan 23	Complete.
3.1 Chair's report	**30 Nov 2022**	Clinical leadership to be added to the agenda for discussion at a future meeting.	PG	March 23	Added to board forward plan for March 2023.
4.1 Board assurance framework	**30 Nov 2022**	Discussion points to be considered as part of the on-going development of the BAF.	CP	Jan 2023	Agenda item.
5.1 Integrated care strategy	**30 Nov 2022**	Discussion points to be taken forward as part of the development of the Integrated Care strategy.	JM	Jan 2023	Discussions points have been shared and will be taken forward as part of the development of the Integrated Care Strategy.
5.2 Integrated Care System	**30 Nov 2022**	Discussions points to be taken forward as part of the on-going development of the Integrated Care System Workforce Strategy.	FO	March 2023	Discussions points have been shared and will be taken forward as part of the on-

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
workforce strategy					going development of the Integrated Care System Workforce Strategy.
6.0 Finance and performance overview	**30 Nov 2022**	Discussion points in regard to future finance and performance reports to be taken in to account and consideration to be given as to what needs to be reported at Place level and what needs to be reported at board level by way of an exception report.	HB	Jan 2023	Revised format for the report is being piloted and is included in the January board papers following a review at the Finance, Performance & Investment Committee on 6 January 2023.
8.0 Board forward plan	**30 Nov 2022**	Discussions to be held at the local authority chief executives meeting, voluntary sector collaborative and Healthwatch collaborative about items they would like included on the forward plan.	CP/ MP	Jan 2023	Nothing further to add to forward plan following the conversations but will follow up.

CLOSED ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
2.0 Resident story	**28 Sept 2022**	A summary outlining the action that will be taken by the board will be sent to the carer. A follow-up will be made so that the carer is involved in the on-going dialogue. An update on the progress made as a result of the carer's experience having been shared to be given at the next meeting.	CP CP CP	Oct 2022 Oct 2022 Nov 2022	Complete. Covered under 1.3 – matters arising.
4.1 System quality, safety and	**28 Sept 2022**	The board delegated the on-going development to the Quality, Safety and Improvement Committee and asked for an update at a future meeting.	IR/DJ	Nov	Complete. Covered as part of the Quality, Safety and Improvement Committee's

CLOSED ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
improvement report					exception report - agenda item 7.2.
5.0 Development of the Integrated Care Strategy	**28 Sept 2022**	Workforce to be included as one of the building blocks in the Integrated Care Strategy.	HR	Oct 2022	Complete.
7.0 Finance and performance overview	**28 Sept 2022**	Information on how cost improvement plans link into our priorities for productivity as a system to be included in the next report. Future performance reports to include deep dives to demonstrate the level of action being taken as a system to address any challenges in regard to the constitutional standards; active dashboards; run charts. Information on population growth and the cost per resident to be included in the next report.	HB HB	Nov 2022 Nov 2022	Will be incorporated into the finance and performance reporting going forward. The month 7 report contains more detail on productivity and performance deep dives. Will form part of the place-based reporting. Specific cost per resident analysis will take place as part of the annual budgeting process for determining resource allocation.
8.1 Governance update and outcomes of July board development	**28 Sept 2022**	A report explaining what ICB board members responsibilities are in regard to the health and social care workforce to be presented at the next meeting.	DH/ FO	Nov 2022	Complete. ICB board members have a responsibility to agree a workforce strategy and the progress/next steps on this are outlined in item 5.2 on the agenda.

CLOSED ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
		An update on the final principles to be given at the next meeting.	CP	Nov 2022	Complete. Included as part of the governance handbook under agenda item 7.5
8.2 Risk management update	**28 Sept 2022**	The feedback given to be taken forward and a board assurance framework (BAF) to be presented to the board at the November meeting.	CP	Nov 2022	Complete. Agenda item 4.0.
9.0 Board forward plan	**28 Sept 2022**	Forward plan to be discussed at the October board development session and presented to the board at the November meeting and published on the website.	CP	October/ November 2022	Complete. Agenda item 8.0.

NHS North East London ICB board

25 January 2023

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 is focused on the North East London Interim Integrated Care Strategy prepared by the North East London Integrated Care Partnership, (ICP). It asks the Integrated Care Board to formally receive the strategy and to note that its contents will inform our Integrated Care Board's (ICB) Joint Forward Plan. The paper also reports on the outcomes of Trust Chair and ICB Non-Executive discussions. • Recommendations: To formally receive and adopt the Interim Integrated Care Strategy to be further discussed under item 4.1. To note the outcomes of North East London ICP and Non-Executive discussions.
Action required	To ensure that the Interim Integrated Care Strategy (ICS) informs the ICB's Joint Forward Plan
Previous reporting	Integrated Care Partnership (ICP)
Next steps/ onward reporting	• That the Interim Integrated Care Strategy updates are provided as a standing item in the Chair's report. • Non-Executive views are taken into account by this Board.
Conflicts of interest	None
Strategic fit	• To improve outcomes in population health (the Interim Integrated Care Strategy informs our Integrated Care Partnership's strategic priorities to meet the needs of our population, which will inform our Joint Forward Plan) • To tackle inequalities in outcomes, experience and access (through the Interim Integrated Care Strategy strategic priorities) • To enhance productivity and value for money (through clarity and alignment on outcomes and success measures within our strategies as requested by Non-Executives) • To support broader social and economic development (through the Interim Integrated Care Strategy strategic priorities).
Impact on local people, health inequalities and sustainability	The focus on the identified need and strategic priorities within the Integrated Care Strategy will enable the ICS to maximise the impact of our joint work on improving outcomes, tackling health

	inequalities and ensuring sustainability. This is further improved through our commitment to co-produced success measures.
Impact on finance, performance and quality	The Interim Integrated Care Strategy and Non-Executive comments on the joint forward plan will continue to inform our financial strategy, particularly how our resources should enable transformation in outcomes.
Risks	The content of the report will inform strategic risk mitigations, including informing how we approach accountability.

1.0 Introduction

1.1 I am pleased to welcome Cha Patel, to her first Integrated Care Board (ICB) meeting. Cha is our new Non-Executive Member and will take over as Audit Chair from 1st February. I take this opportunity to thank Sue Evans for stepping into the Audit Chair role and for ensuring that we maintained progress. I look forward to working with both Sue and Cha.

1.2 As Chair of the Integrated Care Partnership, (ICP) I am pleased to formally ask the Board to receive the ICP's Interim Integrated Care Strategy (please see below and item 4.1). The strategy sets out the ICP strategic priorities to meet the needs of our population. It describes the needs of our population, how we will address the needs of our population and address health inequalities through the 4 ICS priorities and how we will work differently as a system to do so. It also describes the impacts of the 4 ICS priorities on our population and workforce. Our Integrated Care Board Joint Forward Plan will set out how the Interim Integrated Care Strategy priorities, together with the NHS operational planning requirements, will be implemented.

1.3 The report also informs the Board of the key points arising from NEL Integrated Care System (ICS) Non-Executive meetings, to ensure their views are taken into account in Board decision making

2.0 Integrated Care Partnership

2.1 As Chair of the Integrated Care Partnership I am pleased to present and ask the meeting to receive and adopt the Integrated Care Partnership's agreed Interim Integrated Care Strategy which will be discussed in further detail under item 4.1 on the agenda. This was approved at the ICP's meeting on 11th January 2023 and during its discussion the ICP highlighted the following:

- The role of ICP Members in taking this back to places and health and wellbeing boards to look at what additional actions that will need to be done locally that will complement and help deliver the strategy.
- Workforce should be emphasised in the introduction and how it underpins the ability to fulfil all of the system priorities.
- Clarity of understanding by the removal of acronyms and inclusion of page numbers.
- The reference to social prescribing should be made clearer that it includes all people and not just children and young people.

- Meeting noted that smart objectives are being developed, in consultation and will be brought back to a future meeting ICP meeting. It was noted that objectives and success measures should align with and inform those set by partner members.
- Success measures should include a focus on integration and how this is defined by local people.
- Case studies could be provided on successful models and exemplars and a separate piece of work could be undertaken to provide this. The next iteration could also include more focus on functions that are working and that should be maintained and improved upon.
- There is little reference to quality and its improvement, and this should be emphasised throughout.
- To acknowledge that significant changes in how people work can change with immediate pressures. This can be referred to in the introduction but can be in more detail in the Joint Forward Plan.
- Places are highlighted in terms of primary prevention, but places also have a focus on secondary and tertiary prevention and this should be made clear within the text.
- Importance of social care as a partner should be expanded throughout, especially for long term conditions.
- Cost of living is a current challenge but our focus should be on poverty as a constant challenge, pre and post cost of living.
- To clarify if the reference under population should say minority ethnic rather than mixed ethnicity.
- The strategy needs to include the ICS agreed Design Principles, particularly relevant to achieving the High Trust Envirnonment, noting there was a lot of work on this.
- Reference the need for equity with all partners including the voluntary, community and social enterprise sector, necessary for to enable co-production with diverse communities, delivery and creating a high trust environment. Achievement of equity will need to consider resource allocation.

Next steps agreed:

- Comments will be reviewed and incorporated into a final interim strategy, which will be published on the website and adopted by the North East London Integrated Board, informing the Joint Forward Plan.
- To look at how it will be part of all joint partners plans and feeding back
- The next meeting can discuss what information the ICP will need as a partnership to ensure the strategy is moving forward on the priorities.

2.1.1 The Board is asked to formally receive and adopt the Interim Integrated Care Strategy.

2.1.2 The January ICP meeting also considered the development of the Joint Forward Plan, (JFP):

Comments included:

- Whilst understanding that this a plan for the delivery of NHS services, it still could recognise that there are elements where local authorities and other partners have obligations and can have valuable input, such as with climate change. In response it was acknowledged that the development of the plan is currently more NHS focussed and it was confirmed that later iterations will incorporate all system partners.

- There is also no reference to the contribution of the voluntary and community sector.
- There are already good examples of integration work and co-production that should be highlighted.
- Organisations should move away from focusing on separation of partners and instead move to describing an integrated partners' way of working.
- Local authorities will be represented on the Joint Forward Plan development group.
- The ICP steering group is continuing and the terms of reference will be presented at the next meeting for approval.
- The ICP steering group will also consider how the ICP should receive updates on the JFP as it develops.
- The JFP should also be presented to established forums such as the meeting of Local Authority leaders, HealthWatch and Voluntary sector group meetings.
- This is a five-year plan but it will be updated annually. An operating plan is also being developed which will have detailed numbers which will be used to reference in the JFP.

3.0 Chair and Non-Executive Activities

3.1 The NEL Trust Chairs and ICB Non-Executive members' November meeting received an update on the development of the ICB's Joint Forward Plan, (JFP). As already noted above, the JFP will set out how the Interim Integrated Care Strategy priorities and NHS operational planning requirements will be implemented so that we are able to meet both the aims and ambitions of our ICS and ICB performance requirements. In their discussion, the Non-Executives noted that there was a great deal of good work happening across North East London and it was important to build on this. The meeting also recognised that whilst specific public engagement is planned in the Spring, which will inform the strategy further, there is already a range of information and quality insight gathered from our community to inform the JFP, given the tight deadlines for completion. There was a clear Non-Executive request that within all sections, the JFP focus should be on the outcomes we would wish to achieve and how this transformation would be achieved.

3.2 The Non-Executives' meeting also discussed the NEL submission to the Hewitt Review. The Right Honourable Patricia Hewitt has been asked by the Chancellor of the Exchequer, Jeremy Hunt, to undertake a review of the targets that need to be set by the NHS nationally to be able to understand ICB performance in relation to the 4 key aims they have been set. The review has 3 key areas to make recommendations, including how the role of the Care Quality Commission (CQC) can be enhanced in system oversight. Whilst the deadline for submissions to the review was the 9th January 2023, the Non-executive discussion provides insight into ways in which we could develop our own mutual accountability frameworks for the delivery of our ICP and JFP strategies. The meeting consensus was that there is a need for agreed, clear, local community informed targets and success measures, and these should be related to our ICB aims and ambition. However, the meeting also agreed that whilst we needed a sufficient number of measures to track progress, the administration of these requests for related information or meetings, should not be so taxing or duplicative of other regulatory requests, that people have less time to focus on the actual implementation. The need to develop digital capability to share data in real time and to enable us to efficiently share

information, with an agreed interpretation of its meaning, was also highlighted. The meeting was clear that the role of the ICB was not to focus on operational performance management, as other mechanisms existed for this, but on establishing a framework for achieving improved outcomes. It was recognised that this meant a different relationship with NHS England (NHSE), nationally and regionally, and more accountability to each other and our local communities. There is a need to define the role of the regional team, with clarity on what is most appropriate and at what level, Including clear NHSE expectations of ICBs, Regions, or trusts, reducing duplication.

4.0 Recommendation

4.1 The Board is asked to formally receive and adopt the Interim Integrated Care Strategy

4.2 The Board is asked to note the outcomes of North East London ICP and Non-Executive discussions.

Marie Gabriel – Chair
13/01/2023

NHS North East London ICB board

25 January 2023

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.
Action required	Note and receive the summary of compliance against NHSE requirements on emergency preparedness, resilience and response (EPRR)
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. • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The 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 It has been another busy period following the last board meeting with a focus on continuing to work closely with partners and further embed the Integrated Care Board's (NHS North East London's) role, particularly its role as a convenor and bringing together partners across the system through workshops and key discussions. You will see from the agenda item that the initial draft of the Integrated Care Strategy is now complete following an extensive period of engagement. This is a fantastic piece of work shaped by partners and provides a clear framework for our activities as a system. The full version will be published in June and we will continue to iterate and refine it. Over December and January, the focus has been on system resilience, refining our winter plan as a system and ensuring we have the mechanisms in place to manage the ongoing pressures. The following report provides an overview of my recent activity and focus.

1.2 This paper is for information.

2.0 System resilience

2.1 December and January have been extremely pressured for local health and care services. At the point of the finalisation of this paper, two days of industrial action by London Ambulance Service (LAS) members of staff have taken place. Significant planning and work supported the system response both across London and in north east London to ensure local people could receive emergency care when they needed it, led by Francesca Okosi, Chief People and Culture Officer and senior responsible officer (SRO). A further strike is expected on 23 January. Local NEL clinicians assisted LAS on the strike days by assessing the clinical priority of callers to the 999 service. There will be a "lessons learned" exercise which includes an evaluation of the effects for local people.

2.2 There has been significant media coverage about the pressure on the NHS and the extent to which this provides a fundamental challenge. As noted above there is very significant pressure on some of our pathways in particular, including urgent and emergency care and primary care, and we have seen increased demand, including increased acuity and complexity across many areas including mental health. Social care colleagues reflect similar pressures to us. We know that our workforces bear much of the brunt of this pressure, and local people often have to wait longer than we would want them to. All of this provides a burning platform for change, as set out in the integrated care partnership strategy. However, it is important that we maintain a focus on the huge amount of good work that continues to go on across the integrated care system and the many people who are supported every day with excellent care and health services. As the performance report shows, there are areas in which waiting lists are reducing and we know that we have some of the highest performing general practices in the country in terms of access to urgent care.

3.0 Hewitt Review

3.1 The Rt Hon Patricia Hewitt, Chair of the Norfolk and Waveney ICB has been tasked by the Chancellor and Secretary of State for Health and Social Care to undertake a review in to the oversight and governance of integrated care systems looking at how best to enable ICSs to succeed. In December a call for evidence was launched and as an ICB we have submitted a response to a series of questions posed in the review.

4.0 Organogram of the ICB

The Secretary of State for Health required all ICBs to produce an anonymised, searchable organogram (here) by 6 January 2023 showing the structure of teams, grades and salary costs. It is important to note that while we complete the organisational restructure this information is subject to change.

5.0 CQC reports on Urgent Treatment Centres (UTCs) in Barking and Dagenham, Havering and Redbridge

In November 2022, the CQC inspected the four UTCs run by the Partnership of East London Co-operatives (PELC) at Queen's, King George and Barking Hospitals as well as Harold Wood Polyclinic. While inspectors noted good practice in a number of areas such as the caring approach of staff and the improvements made in safe and appropriate use of medicines, safeguarding and care plan management, the inspection found serious concerns regarding the streaming and triage of patients.

Consequently, the Care Quality Commission (CQC) has rated all four services as 'inadequate' and PELC has been placed into special measures and given specific recommendations on actions required to improve its position. On 14 November, a detailed action plan was submitted and 14 out of 21 actions identified by the CQC had already been completed. An assurance Board, chaired by one of the ICB associate non-executive members (NEMs), has been set up to oversee improvement, reporting in to the Quality, Safety and Improvement Committee of the ICB.

We know that there are significant pressures and areas for improvement across the pathway for urgent and emergency care in outer north east London. We met as a system before Christmas to agree a series of actions to tackle weaker areas of performance and progress will be reported through the Urgent and Emergency Care delivery board.

6.0 Next steps for primary care – Fuller review

The publication of 'next steps for integrating primary care: Fuller Stocktake report' in 2022 created a new vision and case for change for integrating primary care. Following the launch of this national report at a regional event in London, we held a system wide face-to-face workshop launch event on 29 November 2022 to inform future planning across north east London.

I was delighted to welcome the author of the report, Prof Claire Fuller, Chief Executive for Surrey Heartlands Integrated Care System and GP, as our keynote speaker. We set out our strategic context and showcased some of our work before moving to four breakout sessions aligned to our four NEL Fuller workstreams: Urgent and Emergency Care; Continuity of Care; Enablers - People; Enablers - Infrastructure.

This was a well-attended and thoughtful event that brought together over 200 leaders from across health and social care to reflect on the recommendations of the Fuller Stocktake report and launch a shared commitment to delivering the Fuller recommendations for our population. We are in the process of progressing the north east London Fuller work programme, aligned to existing workstreams, and the output from the launch event will be integral to the workstream priorities.

One of the immediate priorities for the Fuller work programme is a comprehensive baseline mapping exercise with place based partnerships to highlight any areas of

good practice, prioritisation areas, as well as identifying gaps against the Fuller Framework for shared action.

7.0 System visits

7.1 **Royal London Hospital with Amanda Pritchard, NHS England CEO** – In November I joined a visit with Amanda Pritchard at the Royal London Hospital where she was combining a visit to the Remote Access Emergency Coordination Hub (REACH) service with filming her Christmas message to NHS staff. REACH is a specialist service staffed 12 hours a day by emergency medicine consultants and is available to NHS 111, so patients can be offered virtual consultations on the most appropriate emergency care instead of going to A&E. This model is an excellent example of how different parts of the system are interconnected. During my visit I also spent an hour in the emergency department (ED) reception watching the flow of people gaining insight into the wide range of issues people bring with them.

7.2 **Newham Hospital and primary care** – during my visit in December I saw first-hand the impact of pressures on children's services due to rising infections and how services are managing this demand. I visited two primary care practices in Newham – including Balaam surgery, one of the best in London for same day access to primary care. They achieve this through a mix of technology, team work and clear focus.

7.3 **Queen's hospital** – I spent a day working on site at Queen's and spent time walking through the urgent and emergency care pathway where they have made a number of improvements which are starting to have a real impact. I also visited the paediatric and special care baby units.

8.0 Homerton emergency department and neo-natal intensive care unit. I recently visited the emergency department at the Homerton as well as the NICU and met some of the amazing staff who work there. It was clear that the clinicians are really focused on supporting the children they care for and their carers.

9.0 Good news stories

9.1 **Recent award success** – Congratulations to the City and Hackney place-based partnership and partners for winning the place-based partnership award at the HSJ award in November. The award was for the alliance model of dementia care from diagnosis to end of life. The integrated service oversees the care for all patients in City and Hackney who are diagnosed with dementia, backed by a shared digital care plan. By taking a collaborative approach – involving GP practices, hospital trusts, the voluntary sector and local authorities – it ensures patients receive care ongoing and timely support from their named health professional.

9.2 I would also like to say congratulations to Healthwatch Hackney for winning a national award for improving access to GP services for local refugees, asylum seekers and other residents. The national Healthwatch Impact Award celebrates the difference made by local Healthwatch staff and volunteers to improve NHS and care services. When patients feel unwell and need help, the GP is often the first place they turn to. For refugees, migrants, and people who are homeless, getting access to basic care can be difficult if services ask to see documents such as passports or proof of address to register. Healthwatch Hackney, the health and social care champion for the London Borough of Hackney, found this issue was affecting people in their community, with some telling them the NHS had refused them Covid-19 vaccinations because they were not registered with a GP. Thanks to a focused effort, most local practices now have the correct registration policy, making it easier

for patients to access a GP and helping to ensure more vulnerable people in their borough can see a GP.

10.0 **Emergency, Preparedness, Resilience and Response (EPRR) – statement of compliance**

I attach as an appendix to my report, the 2022 statement of compliance. As part of the Emergency Preparedness, Resilience and Response assurance process, all NHS organisations are required to carry out a RAG (red, amber, green) rated self-assessment against the NHS Core Standards for EPRR. The self-assessment is based on a comprehensive submission of evidence including policies, plans and details of best practice.

For 2022/23, NHSE England and the ICB agreed a level of 'Partially Compliant', with seven amber and 40 green ratings for the core standards. The EPRR lead has authored a comprehensive workplan for 2023 which will support the ICB to reach a fully compliant position by September 2023.

NHS England noted that the feedback given was not reflective of any concern toward the ICB's capabilities to deliver key EPRR functions for NEL ICB and support the NEL network. The Panel felt assured that the ICB was and would continue to be a valuable asset to the NEL Network and to the wider London Health system.

The board is asked to receive the statement of compliance.

Appendix: Emergency, Preparedness, Resilience and Response Statement of Compliance - 2022

Zina Etheridge
January 2023

Appendix: Emergency Preparedness, Resilience and Response (EPRR) Statement of Compliance –2022

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services. NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements against which all NHS organisations are required to self-assess their arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet and the Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

The year 2022 saw Integrated Care Boards become statutory bodies under the Health and Social Care act 2022. With this adjustment in legislation, ICBs became 'category one' responders and strategic leaders for their systems during critical and major incidents. The EPRR team conducted a work programme to enable the ICB to be compliant against the NHS EPRR Framework which included a new policy suite, system level EPRR meetings, EPRR Engagement Strategy and a statutorily required role at every Borough Resilience Forum.

The NHS services continue to recover from the impacts of Covid-19, whilst managing other system challenges that occur. During 2022, the NEL ICS system has responded to incidents such as heatwaves, residential fires, emergency evacuations, supply chain issues and the impacts of Industrial Action. In addition, the ICB led the NEL response to outbreaks of infectious diseases such as such as Mpox, Polio, Strep A and Diphtheria.

NEL ICS were able to respond to these challenges with stronger, more effective and collaborative incident management. This not only supports the ICB to meet some of its key objectives, but also supports our patients to continue to access the healthcare they need during times of crisis for our services.

As part of the 2022 assurance process, all organisations were required to carry out a RAG rated self-assessment against the NHS Core Standards for EPRR. The self-assessment was based on a comprehensive submission of evidence including policies, plans and details of best practice. This was submitted in October 2022, with an assurance meeting held with NHSE London and the AEO and EPRR Lead in December 2022.

Level of Compliance

In respect of North East London Integrated Care Board for Core Standards 1 – 68, the following RAG ratings were agreed at the review meeting:

Red ratings	Amber ratings	Green ratings
0	7	40

Total number of red / amber ratings	7

NHSE England and the ICB agreed a level of **Partially Compliant**.

The ICB received Amber ratings for the following core standards:

- Core Standard 2: EPRR Policy Statement
- Core Standard 5: EPRR Resource
- Core Standard 16: Evacuation and Shelter
- Core Standard 22: EPRR Training
- Core Standard 25: Staff Awareness and Training
- Core Standard 44: BC Policy Statement
- Core Standard 45: BCMS scope and objectives

Several of the above areas were self-assessed by the ICB EPRR Lead as partially compliant, including that of EPRR Resource, Evacuation and Shelter, EPRR Training and Staff Awareness and Training. The EPRR lead has authored a comprehensive workplan for 2023 which will support the ICB to reach a fully compliant position by September 2023. This workplan is available on request.

NHS England Compliance Meeting Feedback

NHS England stated the following:

Evidenced through this year's assurance process, the NEL ICB, through the commitment of the EPRR Lead in conjunction with and support of the ICB AEO, have demonstrated good practice in the delivery of the 2022 core standards. The success of this year's assurance process was reflected in the success of EPRR across the system. The commitment shown by the ICB EPRR Lead is further reflected in the professional relationships made and engagements with the NEL Trust Emergency Planning Teams, the NHS England (London) Regional EPRR Team and through multi-agency engagement across the network.

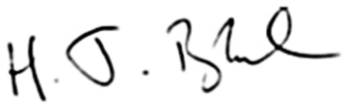
Both the Panel and ICB agreed on the partially compliant assurance rating due to various areas of the core standards needing further development. The ICB has made notable progress through the transition to ICB and in establishing themselves within the NEL network over the last year, especially in the context of external and internal challenges which have impacted the organisation.

The raised areas of concern that were highlighted in this year's assurance process were not reflective of any concern toward the ICB's capabilities to deliver key EPRR functions for NEL ICB and support the NEL network. The Panel felt assured that the ICB was and would continue to be a valuable asset to the NEL Network and to the wider London Health system.

Conclusion

The North East London system partners collaborative approach to emergency preparedness, resilience and response has ensured that our population continues to receive quality healthcare under a time of national challenge. New incidents above and beyond system pressures have proven the strength of the system's mutual aid agreements, inter-relationships between trusts, commissioners and providers, and ushered in new ways of treating patients and working together. We are confident that, although the winter will bring increased seasonal and circumstantial pressures, the system and ICBs constant and consistent learning approach will support us to implement and embed best practice as we encounter new and unforeseen challenges.

I would like to thank all colleagues who have supported EPRR and Incident Response in 2022/23 and those who continue to work for, and with, North East London NHS.



Henry Black

Accountable Emergency Officer
NHS North East London Integrated Care Board

NHS North East London ICB board

25 January 2023

Title of report	Integrated Care Strategy
Author	Hilary Ross, Director of Strategy, NEL ICS
Presented by	Johanna Moss Chief Strategy and Transformation Officer
Contact for further information	hilary.ross1@nhs.net
Executive summary	• We presented a final draft of the interim integrated care strategy to the integrated care partnership on 11 January. The paper discussed by the ICP which includes the final draft of the strategy is included in your pack. • As well as our system wide workshops we engaged with provider collaboratives, place based partnerships and health and wellbeing boards on the development of the new strategy. There is broad agreement on the priorities, cross-cutting themes and foundations for a well- functioning system in NEL as set out in the strategy. • As such, the interim strategy sets a clear direction for the current planning round including the new NHS Joint Forward Plan due for submission before the end of March 23. • We are currently making final minor amendments to the draft in your pack following the ICP meeting and ahead of publication online. • The interim strategy will be tested further with local people at a 'Big Conversation' being planned for the Spring and reviewed again following the publication of further guidance expected in June 23. Further work is also to be undertaken to develop the success measures into SMART metrics will enable us to measure and report progress.
Action required	Adopt.
Previous reporting	Discussions have taken place with the ICP Steering Group and full partnership, the ICB Board and Executive Committee, the NEL CAG, place based partnerships and health and wellbeing boards.
Next steps/ onward reporting	The interim strategy has been agreed (subject to some minor amendments in the text) by the Integrated Care Partnership at their next full meeting on 11 January 2023.
Conflicts of interest	N/A

Strategic fit	Which of the ICS aims does this report align with? • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The strategy aims to set a new and ambitious direction for coproduction with local people and ensuring that tackling health inequalities and securing equity is core to all that we do across our system.
Impact on finance, performance and quality	While the strategy sets the overall direction for the system the financial, performance and quality implications will be set out through the Joint Forward Plan, which is the new five year delivery plan for the NHS, and annual operating plans.
Risks	This is an ambitious strategy setting out a radical new approach for how we work together as a system. There is a risk that we revert to old ways of working and behaviours especially given current system pressures.

North East London Health & Care Partnership

NHS North East London

Update on development of NEL Integrated Care Strategy

25 January 2023

Progress update

- We have continued to develop the integrated care strategy following discussion and feedback from Health and Wellbeing Boards, place based partnerships and provider collaboratives; and following our series of workshops with stakeholders from across the system.
- The draft interim strategy included in this pack is to be discussed at a full meeting of the Integrated Care Partnership on 11 January – this follows a workshop held with them in December to review the four system priorities and six cross-cutting themes.
- Once we have received final feedback from the partnership we will publish a version of the interim strategy online pending publication of further guidance from the Department of Health and Social Care expected in June 2023.
- The interim strategy will inform the planning round in 2023/24 including the new Joint Forward Plan (NHS five year delivery plan) due to be submitted to NHSE before the end of March 2023 and the annual operating plan for the NHS.
- We will continue to develop the strategy including testing the actions and success measures with local people through a 'Big Conversation' planned for Spring 2023.
- We will develop the success measures outlined in the strategy into 'SMART' goals in order that our integrated care partnership can track and report progress to local people.
- In line with our learning system approach and partnership ethos, we are committed to continuing the dialogue with local health and wellbeing boards, place based partnerships and provider collaboratives to support ongoing alignment across the system.

Questions for the partnership

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

2) Have we set the right level of ambition and scope in our success measures for the new system strategy recognising that further work will need to be undertaken to develop them into measurable goals?

North East London Health & Care Partnership

NHS North East London

Interim North East London Integrated Care Strategy

January 2023

Final Draft (v.6.1.23)

Introduction

Where we begin our story

In July our **Integrated Care Partnership (ICP)** was formally established. This is a statutory committee that brings together a broad set of system partners (including local government; the voluntary, community and social enterprise sector; NHS organisations; and wider partners) to work together to plan and deliver joined up health and care services.

*One of the first requirements of our ICP is to develop an **integrated care strategy** for north east London (NEL).*

Our partnership brings huge potential to work together as a system towards a much **greater focus on population health outcomes and tackling inequalities**. However, it is important to recognise and acknowledge the **challenging context** many parts of our system are facing at this point in time as we come together as a partnership to develop our new integrated care system. Our integrated care partnership serves one of the **most deprived populations** in the country where inequalities are stark. Our population is under increasing pressure in the wake of the recent **COVID-19 pandemic** which exacerbated health inequalities and brought longer term impacts to the physical and mental health and wellbeing of local people, impacting individuals, households and communities in ways that are still not fully understood. In addition, we know that the **cost of living crisis** is further impacting local people, the majority of whom (70%) have told us they are currently struggling in one or more aspects of daily life, be that in their health, housing, income, food or with loneliness.

Furthermore, these challenges are set to grow as **unprecedented population growth** redefines our communities over the coming decades, and the health and care needs of local people continue to increase in complexity as our overall population ages.

The **challenges currently facing our health and social care staff, teams and organisations** working within north east London cannot be underestimated. Services are currently seeing extreme winter pressures with unprecedented demand for care, particularly urgent care, from our population. There is huge demand for planned care which was so heavily impacted by the pandemic with an urgent need to address long waiting times and inequity. Our workforce has a high number of vacancies which places a greater burden on staff, increasing stress and burnout. There is also an additional challenge of managing the impact of industrial action.

These huge challenges create a 'burning platform' for action as an integrated care system – we cannot continue to work in the same way, doing the same things. Partners in NEL are clear that we need a **radical new approach to how we work as an integrated care system** to tackle the challenges we are facing today as well as securing sustainability for the future.

This **strategy is intended to provide the framework for our partnership** to do that. It does not provide all the answers or reference the full range of work we will need to do take this forward, but it signs us up as a partnership to a clear set of priorities, core themes for working differently and some key foundations for our system.

Our strategy in a nutshell

Partners are clear that a radical new approach to how we work as a system is needed. Through our engagement we have identified **six cross-cutting themes** which will be key to developing innovative and sustainable services with a greater focus upstream on population health and tackling inequalities.

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

Local employment and workforce is one of ***four*** **priorities that stakeholders across the partnership have agreed to focus on together as a system.** There are of course a range of other areas that we will continue to collaborate on, however, we will ensure there is a particular focus on the agreed system priorities and have been working with partners to consider how all parts of our system can support progress.

Broad engagement including a series of well attended system-wide stakeholder workshops, discussions with Health and Wellbeing Boards and place based partnerships has shaped our plans for improving outcomes and tackling inequalities as well as improving access and experience in these areas.

We recognise that a **well-functioning system** that is able to meet the challenges of today and of future years is built on **sound foundations.** Our strategy therefore also includes an outline of our plans for how we will transform our enabling infrastructure to support better outcomes and a more sustainable system.

It includes some of the elements of our new financial strategy which will be fundamental to the delivery of greater value as well as a shift in focus 'upstream'.

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

Our 6 crosscutting themes underpinning our new approach as an ICS

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

Our four system priorities for improving outcomes and tackling health inequalities

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

Our key areas for securing the foundations of our system

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

The north east London picture

A snapshot of our population

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

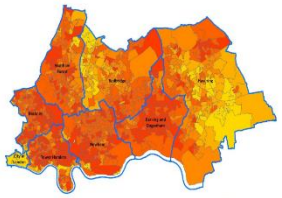
Our rich diversity. North east London is made up of many different communities and cultures and there is an opportunity to draw on a diverse range of community assets and strengths.

Our diversity underlines that a 'one size fits all' approach to services does not work for the people and communities of north east London.

Just over half (53%) of our population are of black, Asian or mixed ethnicity – we know that significant health inequalities exist between ethnic groups; this was highlighted and exacerbated by Covid-19.

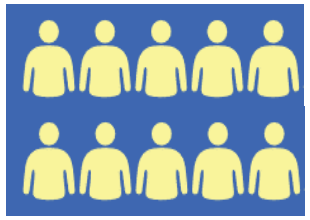
We are densely populated and growing rapidly. Our two million residents are spread from the densely populated, inner city areas of Hackney and Tower Hamlets out to Havering. By 2041, we expect to have an additional 400,000 residents, the equivalent of adding another borough's worth of people.

This means that we must take bold action now to improve our services, building capacity and resilience to create the best health and wellbeing outcomes possible for our future population.



We have high levels of deprivation. Nearly a quarter of our residents live in one of the most deprived 20% of areas in England; and overall, among our boroughs, Barking & Dagenham is ranked 21st, Hackney 22nd, Newham 43rd, and Tower Hamlets 50th most deprived of all (312) England local authority areas.

Poverty and deprivation are key determinants of health and our place based partnerships and provider collaboratives are seeing first-hand the impact that cost of living pressures are having on our communities.



We have a young population. While our 0-18 years population is broadly similar to England ie children and young people account for a quarter of our population (though this rises to nearly a third in Barking & Dagenham), it is our disproportionately large working age population that sets us apart from other parts of England.

Our inner London places tend to have a larger proportion of working age people currently, whereas outer London tends to have a larger population of older people leading to different health and care needs across places. However, this is changing as growth projections suggest large increases in older people over the coming decades, particularly in inner London, leading to over 260,000 additional over 60s projected by 2041, an increase of 115%.

While working age people tend to be healthier, this is not necessarily the case in NEL as all our places have a higher proportion of working age people unemployed and self-employed than the England average, and an estimated 13% of employed residents earn less than the London Living Wage. Almost a third of our population is living with one or more long term condition despite their relative 'youth'.

Many of our children are growing up in low income households. A quarter of children from Tower Hamlets, Barking & Dagenham and Newham, and substantial numbers in our other boroughs are growing up in low income households.

We know that this has a strong correlation with poorer health outcomes, and in particular the social and emotional wellbeing of children.

Children and families with the lowest 20% of household income are three times more likely to have common mental health problems than those in the wealthiest 20%.

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

Living in the context of the recent pandemic and cost of living increases

70% of our population is struggling in one or more aspects of daily life: finance, work, food, housing, loneliness; and groups more likely to struggle across multiple domains include people from an ethnic minority background, people with children, people of working age and people born outside of the UK.

Findings of a recent survey in NEL:

- 20% of our population have not had enough money to buy food when needed; this is more often true for ethnic minority groups, young people, those with long term health conditions, and those who don't speak English well or were born outside of the UK.
- 15% of residents unable to adequately heat their home.
- 14% consider their housing to be poor or very poor quality.
- 20% with loans struggle to keep up with debt repayments.
- 28% feel lonely some or often/all the time - this is especially so for the young or those with a long term health condition .

Reference: GLA Survey of Londoners (2022)

Our partnership in north east London

Our ambition and priorities

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

Working together as a partnership we agreed four priority areas:

Babies, children and young people	To provide the best start in life for the **Babies, Children and Young People** of North East London
Long-term conditions	To support everyone at risk of developing or living with a **long term condition** in north east London to live a longer and healthier life
Mental health	To improve the **mental health** and wellbeing of the people of north east London
Local employment and workforce	To create meaningful **work** opportunities and **employment** for people in north east London now and in the future

Our partnership

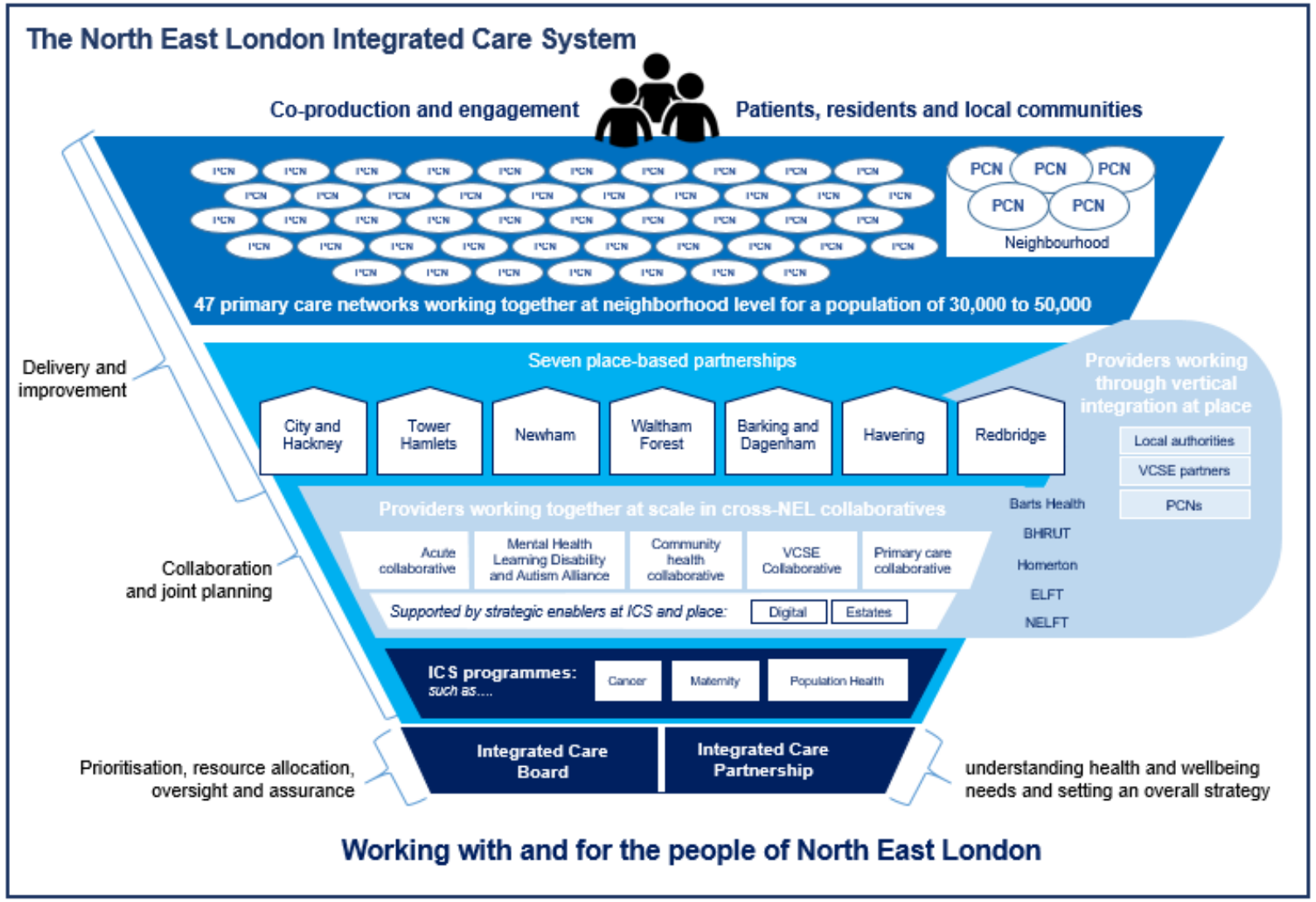
We are a broad partnership, brought together by a single purpose: to improve health and wellbeing outcomes for the people of north east London.

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

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

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

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



How we work together as an integrated system – our six cross cutting themes

Tackling health inequalities

Our context

Nearly a quarter of local people live in one of the most deprived 20% of areas in England and more than 1 in 5 children in some boroughs live in poverty. People living in poverty experience poorer mental health, live in poorer quality housing and are less able to afford products and services than underpin good health. The recent pandemic and cost of living pressures bring additional challenges for our poorest residents and exacerbate existing health inequalities.

More than half of our population in NEL are from a minority ethnic background. The pandemic highlighted and widened inequalities between ethnic groups and evidence is clear that collecting ethnicity data, measuring and addressing ethnic disparities in healthcare access, experience and outcomes, and addressing racism and discrimination, are crucial to efforts to reduce health inequalities.

We estimate there are nearly 52,000 people in NEL with a learning disability. People with learning disabilities and autistic people have greater and more complex health needs and experience higher levels of unmet health need than the general population, and are more likely to face multiple barriers to accessing services. People with learning disabilities in NEL were 4.8 times more likely to die than those without during the first phase of the pandemic.

Housing is a key determinant of health, and homelessness and inadequate housing are significant and increasing problems across NEL. Mortality among people experiencing homelessness is around ten times higher than the rest of the population, yet many of these deaths are preventable. The homeless population face barriers to accessing health and social care services including stigma and discrimination and rigid eligibility criteria for accessing services. We need to ensure that the housing planned in NEL is of the mix and quality local people require to support better health outcomes and prevent further burden on our system.

We estimate that 17% of our population in NEL may provide informal care. Informal carers make a significant contribution to supporting the health of vulnerable people, yet evidence suggests that carers themselves are at risk of poor physical, mental and financial health outcomes.

NEL is the most deprived ICS area in London as well as one of the most deprived nationally. Deprivation is about more than poverty. It takes into account a range of factors in the population and environment including housing and education as well as income. Deprivation is associated with higher risk factors for poor health (for example poor diet and smoking) and poorer health outcomes.

Key areas for system action

- Applying a poverty lens to all our work. This includes paying particular attention to the health and social needs of people living in poverty, reviewing their access to and usage of services, tackling unmet need, and addressing the wider determinants through making every contact count and our role as anchors.
- Ensure we are measuring and addressing ethnic disparities including in our waiting lists, also a strong focus also on cultural competency, building trust and tackling racism as evidence tells us this will be key to tackling health inequalities.
- Support for carers running through all our priorities and other transformation programmes.
- Ensure all services are accessible, appropriate and effective for people with learning disabilities and autism, increase the number and quality of annual health checks and vaccinations for COVID-19 and flu and reviewing deaths to ensure we have up to date data and action plans to address health inequalities.
- Collaborate to improve health and care services for people experiencing homelessness and reduce the mortality gap between people who are homeless and the rest of the population.
- Build our understanding and recognition of intersectionality.
- Review the impact of local place based partnerships in reducing health inequalities and accelerate and invest in scaling up good practice.

What success looks like

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

- Across north east London we are reducing the difference in access, outcomes and experience particularly for people from minority ethnic communities, people with learning disabilities and autism, people who are homeless, people living in poverty or deprivation and for carers.
- Healthy life expectancy is improved across NEL and the gap between our most and least deprived areas / those living in poverty and the wealthiest is reduced.
- We routinely measure and address equity in NHS waiting lists supported by improved ethnicity data collection and recording across health and care services leading to delivery of more inclusive, culturally competent and trusted services to our population.
- We understand digital exclusion and ensure new innovations do not widen inequalities.
- We are committed to becoming an intentionally anti-racist system where we prioritise anti-racism, understand lived experience of staff and local people, grow inclusive leaders, act to tackle inequalities, and review our progress regularly.

Prevention

Our context

More than 40% of children in NEL are overweight or obese. NEL has a higher proportion of adults who are physically inactive compared to London and England. Smoking prevalence in adults is higher than the England average in most NEL places, and 1 in 20 pregnant women smoke at time of delivery. All NEL places except Havering have worse screening rates for breast, bowel and cervical cancer than England, and vaccination rates tend to be lower with considerable variation between ethnic groups. Cost of living pressures are likely to make the situation more difficult with, for example, families not able to afford the costs associated with preventive dental care, travel for healthcare appointments, and maintaining a healthy diet.

Most NEL places have a higher prevalence of diabetes compared to the England average, and rates are increasing. For many conditions there are low recorded prevalence rates, while at the same time, most NEL places have a higher under-75 mortality rate compared to the England average. This suggests that there is significant unmet health and care need in our communities that is not being identified or effectively met by our current service offers.

Given the scale of the challenge around some of these risk factors and the population growth expected in NEL, our current services will be unsustainable unless we focus more, as a system, on prevention and early intervention.

Our ambition is to move beyond a medical model focused solely on needs towards a social model of ***health creation*** focused on strengths or assets where power is rebalanced, where local people and communities gain a sense of purpose, hope, and control over their own lives and environment and in doing so enhance their overall health and wellbeing.

Key areas for system action

- We will increase, over time, the proportion of our budget that is spent on prevention (both primary and secondary) and earlier intervention.
- Greater focus for all partners on primary and secondary prevention, supported by Population Health Management. Places will lead on primary prevention whilst primary care and clinical networks will strengthen their focus on secondary prevention.
- Greater system role in promoting social and economic development including action on the wider determinants of health through our role as ‘anchor’ institutions within north east London, where we are major employers of local people.
- Use the data we collect to identify and tackle unmet need, in particular among those living in poverty, people from minority ethnic backgrounds, and other priority groups.
- Work with the voluntary and community sector to support health creation in our communities.

What success looks like

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

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

Personalisation

Our context

Personalised care involves changes in the culture of how healthcare is delivered. It means holistically focussing on what matters to people, considering their individual strengths and their individual needs. This approach is particularly important to the diverse and deprived populations of north east London, where health inequalities have been exacerbated by the pandemic followed by the cost of living increase. Embedding personalised care approaches into clinical practice and care, which take into account the whole person and address all their needs will ensure our most vulnerable communities are supported in the years ahead.

We have built a strong foundation for personalised care over the last three years as a system, with an early focus on social prescribing and personal health budgets. Our vision is to make personalised care central to local population health approaches.

As part of delivering greater personalised care, we want to explore how we can strengthen our understanding and delivery of ***trauma-informed care*** based on the principles of safety, trust, choice, collaboration, empowerment and cultural competence. This is particularly important in the context of the recent pandemic, the cost of living crisis and the ongoing health inequalities experienced by many underserved groups across NEL.

Key areas for system action

- Digital: all of our social prescribing teams will have access to digital templates in primary care. We will develop similar shared digital platforms and solutions for other personalised care interventions such as care plans.
- Evaluation: we will implement our personalised care minimum data-set initially in social prescribing teams and then in other personalised care interventions to evaluate impacts on wellbeing measures like ONS4 (Life satisfaction, Worthwhile, Happiness, Anxiety).
- Workforce enablement: we will work with PCNs and place based partnerships to ensure the personalised care workforce – social prescribing link workers, care co-ordinators and health and wellbeing coaches are consistently supported with CPD - including training plans, leadership development, peer support networks and supervision.
- Supporting proactive social prescribing for identified cohorts: we will work with PCNs and place-based partnerships to support targeted social prescribing for identified cohorts including vulnerable people, specifically building expertise in tackling inequalities through increasing access and support for particularly underserved groups.
- Developing specialised social prescribing services: we will support the development of new specialist roles in response to local population health approaches, like children's social prescribers and social prescribers with expertise in violence reduction/knife crime. We aim for at least one PCN in each place based partnership to have a children and young people social prescribing service, in line with local needs. We will facilitate developing social prescribing across acute, mental health and community providers.
- Community chest programmes: we will invest in social prescribing community chests to increase resources in the community and voluntary sector locally targeted at addressing local inequalities and providing social value to our communities where it is needed most.
- Personal health budgets: we will support our place-based partnerships to expand their personal health budget offer according to local need and in line with our three main population health priorities.

What success looks like

- Staff have access to all the information they need in one place to enable them to provide seamless care to local people and can share this information safely through our IT systems.
- Local people including carers only need to tell their story once through their health and care journey.
- Local people are asked what matters to them in setting their treatment or care goals and can access a wide range of non-medical support in the community.
- Particularly vulnerable people and underserved groups are identified and given additional support to access services ensuring their experience and outcomes of care are equitable.
- Our staff are equipped to deliver trauma-informed care based on the principles of physical and psychological safety; trust; choice; collaboration; empowerment; and cultural competence.
- We will have at least one PCN in each place-based partnership with a CYP social prescribing service, in line with local needs.

Co-production

Our context
At the heart of our system is the shared commitment to co-production and meaningful participation with local people, communities and partners.

Our Working with People and Communities Strategy is a framework document which we are further developing through ongoing engagement with residents and communities, building on the good and wide-ranging practice in place across north east London. The strategy was developed in collaboration with our partners and local people, including public forums and community and voluntary sector groups and sets out our vision to ensure participation is at the heart of everything we do. As it evolves, our strategy will set out in more depth our shared ambition which is firmly aligned to co-production and to the active leadership of local people, service users, carers and patients.

Central to our ambition is our continued commitment to the development of an effective voluntary, community and social enterprise alliance which will ensure that the sector is fully embedded in our ICS, on an equal footing with our provider collaboratives. We also recognise and value the important role of our eight local Healthwatch organisations in communicating the voice of local people and providing insight through our partnership work at place level and their formal place in our governance and decision-making arrangements.

We are committed to ensuring we have a diverse and population focused clinical and care professional leadership, who are focussed on driving change and working hand in hand with local people.

We are committed to taking an asset based approach to participation and engagement, which moves away from focusing solely on needs and problems but truly values the capacity, skills, knowledge and connections which exist within our communities and local people.

Asset based approaches emphasise the need to redress the balance between meetings the health needs of our local people whilst nurturing the collective strengths and resources which exist within our communities. By working with our local people and building on these assets we are better equipped to reduce health inequalities and effectively promote good health and wellbeing.

Key areas for system action
Our commitment to co-production is rooted in a set of co-designed principles for participation, which are grouped under five overarching themes:

- Commitment: we are committed to putting people participation at the heart of our work, from the design of services to participatory budgeting
- Collaboration: we will talk to each other and identify where we can work together to achieve a high standard of participation with the communities we serve, sharing information, learning, resources and building on best practice
- Insight and evidence: we will share insight and produce plans based on evidence and feedback from local people, continuing to strengthen use of the NEL community insight system as an open resource for all partners
- Accessibility: we will ensure participation is accessible to all local people, supported by the development of an Accessibility Champions Programme
- Responsiveness: we will be responsive to the local voice and develop an approach built on reciprocity and partnership

What success looks like
- We can evidence how decisions taken by our boards are informed by the views of local people.
- We helped establish a community and voluntary sector collaborative and actively support and resource its development.
- We have developed models of co-production, learning from and embedding best practice, and train a wide range of health and care staff in co-production and power sharing approaches.
- We have established a vibrant and diverse community leadership programme, to empower local people to work alongside us as partners
- We can demonstrate how we have identified and engaged underserved groups and the full diversity of our local population.
- We use existing sources of insight from local people including carers to shape our strategies and plans at the earliest possible opportunity and resist repeatedly asking the same questions.
- We close the loop when we seek the views of carers and local people by feeding back.

High-trust environment

Our context

Our health and care partnership inherits a legacy of competitive and sometimes adversarial relationships between organisations, which often do not serve local people well. This is based in part on an old financial and contractual regime that encouraged the defence of organisational interests rather than a shared view of how all partners best work together to drive improvements to health, wellbeing, and equity.

This was always at odds with the commitment of partners and staff to do what is right for the people of north east London. With the new health and care partnership, we have the opportunity to ensure that our new ways of working reflect this commitment across our whole system spanning local authorities, the community, voluntary faith and social enterprise sector and health.

This includes defining how place partnerships, provider collaboratives, and NHS North East London each contribute to delivering local ambitions with all parts of the system coming together as equal partners. It also means defining the interfaces between these key building blocks of our system, and the hand-offs between the types of care that they are responsible for, which our experience tells us is critical to effective delivery.

Alongside this, we need to build the environment of high trust that enables seamless delivery across pathways spanning social care, primary and community care and secondary care regardless of organisational or sector boundaries. We define this as an atmosphere of constructive and ambitious engagement, in which each stakeholder acts on the basis of trust in the motivations and capabilities of all other partners.

Only building this truly collaborative and high-trust culture will enable our new partnership to work for local people and within and across local partners; without it, our new structures will have limited impact on the people of north east London.

Key areas for system action

- A co-designed mutual accountability framework will describe how place partnerships, provider collaboratives, and NHS North East London work together to deliver for local people.
- This will set out common ambitions, expectations, and ways of working, describing what each part of the system is accountable for and how each part will be supported to deliver its accountabilities – a critical foundation for trust in both system interactions and behaviours.
- We will also continue to invest in the cultural and behavioural development necessary to ensure that collectively we are making full use of the opportunities of the new partnership.

What success looks like

- Local people trust our services and advice because they feel that their voices are heard and our delivery is culturally competent.
- Partners feel actively engaged in, and know how best to contribute to, partnership work.
- This partnership work is undertaken in a spirit of constructive engagement and shared risk, guided by the aspirations and needs of local people, with issues tackled together without blame.
- All partners adopt an open-book approach to their aspirations, challenges, risks, and finances.
- All partners continually critique how effectively they work together and seek to improve collaboration.

Place partnerships and provider collaboratives

We have **seven place partnerships** working to promote the wider determinants of health and to integrate local health and care services

- Barking and Dagenham, City and Hackney, Havering, Newham, Redbridge, Tower Hamlets, and Waltham Forest

We also have **five provider collaboratives** working across north east London to deliver improvements to care at scale, to tackle unwarranted variation, to promote equity, to share learning, and to provide a strong voice for their member organisations

- the acute provider collaborative; the community collaborative; the mental health, learning disabilities, and autism collaborative; the primary are collaborative; and the voluntary, community and social enterprise sector collaborative

A learning system

Our context

As a system, we are continuously looking for ways that we can improve the quality of care that local people receive and many or our organisations have already invested in developing their improvement methodology and competencies among staff. Equally we are developing a good understanding of the make-up of our population – demography, prevalence of diseases and where there is unmet need [add link to NEL Population Health Profile] – but we do not yet use that information in a systematic way, for the benefit of our population.

Closer working between partners provides an opportunity to improve how we work; to improve how we share data and information between ourselves; and to improve how we learn from each other and spread new and innovative ways of working. We are building from a strong base and have begun the work to share data, including creating linked datasets that bring together information held by different organisations (such NHS trusts, primary care and local authorities) to allow clinicians and planners to better understand the needs of our population, including the wider determinants of health, such as housing and education.

We also doing pioneering research at Barts Life Sciences – a partnership between Barts Health and Queen Mary's University – which brings together scientists and clinicians to create new innovations that benefit the local population, and wider NHS.

As we move forward we will build on these successes to embed evaluation, continuous learning and quality improvement into all that we do.

Key areas for system action

- Give patients and (with patient consent) carers and clinicians involved in their care, better access to their care record.
- Improve data and insights, giving teams easier access to actionable population information, to support the identification of population cohorts for whom interventions will be most effective.
- Improve our evidence base to drive investment in the transformation of services and the deployment of interventions targeted at specific populations to improve health and care outcomes.
- Grow our analytical capacity and capability and ensure that analytics teams are collaborating effectively with clinical direction, including more consistent assessments of local population need across north east London (via JSNAs)
- Increase our appetite for innovation, and use evaluation to understand the impact we have to support scaling up rapidly where we see positive change
- Ensure that every part of our system has a clear methodology for learning and improvement while working towards common approaches across the system as far as possible over time.
- Develop our research strategy to ensure that we are attracting more research in our system, that research is addressing the most important questions for our population, and that more local people can participate in research.

What success looks like

- We use data, evidence and insights to build our understanding of our population and to drive our priorities.
- All staff consider quality improvement a key part of their role and are continually striving to improve services and outcomes for local people.
- We have systematic processes to continually identify people that are underserved by our current care pathways and make changes based on our learning.
- We innovate and enable shared learning to accelerate adoption of innovation, research and best practice throughout our system.
- We support and encourage research that is focused on improving health and care for local people and involve more local people in research.

Population Health (our responsibility)

A focus on improving physical and mental health outcomes, promoting wellbeing and reducing health inequalities across an entire population, including a specific focus on the wider determinants of health (such as housing, employment and education).

Population Health Management (our methodology)

A way of working to help frontline teams and system planners understand current health and care needs and predict what local people will need in the future.

It involves analysing data to identify population cohorts where interventions will add value, intervening, measuring the impact of interventions and incentivising those interventions that add value.

It also involves using the data to allocate resources optimally to population cohorts with the greatest need and to interventions that add most value.

Improving outcomes and tackling inequalities - our four system priorities

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

Our context and case for change

Babies, children and young people comprise one quarter of our population and the GLA birth rate projections predict a significant annual increase in births in Newham and Barking and Dagenham. The population of babies born in NEL is also hugely diverse. More than one third of the population aged 0-18 is of Asian ethnicity, 14% of black and 6% of mixed ethnic backgrounds.

In all our places except Hackney and Havering we have a higher proportion of babies born with a low birth weight than the England average. Babies born to Black and Asian women in north east London are nearly twice as likely to have a low birth weight than those born to White women. Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life.

In all our places except Havering, we have a higher percentage of children living in poverty than the England average (15.6%). There is a strong link between childhood poverty and poorer health outcomes including premature mortality. There is also evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health.

Assessments indicate that 38,000 pupils in north east London need special educational support. 13,600 of these pupils have Educational, Health and Care Plans which outline the support they receive and these numbers are increasing.

In all places in NEL, overweight and obesity in children is higher than the England average (35%). Barking and Dagenham and Newham respectively have the highest and fifth highest rates in England. Dental decay in 5-year olds is also higher in all our places compared to England.

We saw physical and mental health outcomes deteriorate during the Covid-19 pandemic, particularly for vulnerable children and those with long term conditions within disadvantaged communities. In north east London at least 18,099 children and young people have asthma, 1,370 have epilepsy and 925 have type 1 diabetes.

We are currently seeing substantial pressures on child health urgent care services which is likely to be connected to the recent pandemic and cost of living pressures.

Currently there are 3,343 babies, children and young people in north east London with life limiting conditions requiring palliative and end of life care, and this number is gradually increasing. In years 2018 to 2020, there were around 100 infant deaths per year across north east London.

Key messages we heard through our engagement

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

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

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

What we need to do differently as a system

Create the conditions for our staff to do their best possible work including creating a safe multi-disciplinary learning environment spanning teams across north east London, provider collaboratives and place-based partnerships with a focus on co-production, quality improvement and trauma-informed care.
Focus on tackling health inequalities by working with our place-based partnerships to increase support for our most vulnerable children and their families particularly those with learning disabilities and autism, young carers, those living in poverty and insecure housing and those from a black and minority ethnic background, developing an enabling programme of work which addresses workforce challenges, supports data capture and benchmarking, and promotes better communication.
Develop clearly defined prevention priorities supporting place-based partnerships to focus on the most deprived 20% of the population and other underserved groups, as well as a focus across north east London on prevention priorities including obesity and oral health.
Develop community-based holistic care, including supporting family hub development building community capacity, aligning to family hubs and strengthening adolescent healthcare. Through social prescribing and multi-disciplinary teams we will enable links to community assets including the community and voluntary sector and put health inequalities at the heart of our work
Improve the experience and support available for children as they transition to adult services ensuring they receive consistent services which are designed with young people to meet their specific needs with an aspiration that young people will transition at a point that suits them and their development, rather than a rigid service threshold.
Prioritise our children and young people's mental health, recognising the importance of support, and timely access to information, advice and care. We will harness the potential of the digital offer and work with children and young people to design and deliver high quality, accessible services in a range of settings.
Improve support for vulnerable babies, children and young people, including those with long term conditions and special educational needs and disabilities. Helping our BCYP with asthma, diabetes and epilepsy, focussing on personalisation of care, and prevention. Supporting our children and families with special educational needs and disabilities through strengthening safeguarding, addressing workforce challenges and supporting data capture. Extending our services for autistic children and young people including the introduction of a new keyworker scheme.

What success will look like for local people

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

What success will look like as outcomes for our population

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

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

Our context and case for change

31% of local people have a long term condition (which is an illness that cannot be cured) such as diabetes or COPD. Living with a long term condition can impact on many aspects of a person's life, including their family and friends and their work. People with a long term condition are more likely to suffer from further conditions or complications over time, including poor mental health.

Long terms conditions account for half of GP appointments, 70% of inpatient bed days and 70% of the acute care budget. Currently the majority of national spend on long term conditions is in acute or hospital based treatment or care with less spent in the community or in primary care e.g. for diabetes £1bn is spent annually in primary care nationally versus £8bn in acute care.

Long term conditions cannot be cured but when identified early and managed effectively, the impact the condition has on a person and their life can often be alleviated or delayed. Some long term conditions can also be prevented completely through healthier behaviours. In the context of a growing and ageing population in NEL, we must drive a shift towards prevention and earlier intervention and ensure the sustainability of services.

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

Our population has a higher prevalence of type 2 diabetes, and several other conditions including hypertension and chronic kidney disease as well as a higher mortality rate for cardiovascular disease in the under 75s. One in five of our residents has respiratory disease. Further, there are likely to be high levels of unmet need – highest in our 'underserved' communities - that are not showing in the data but require proactive identification and better management.

Two-thirds of people with at least one long term condition have more than one mental health problem, including depression and/or anxiety, and there is a growing connection between living with a long term condition, social isolation and low self-esteem.

Key messages we heard through our engagement

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

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

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

What we need to do differently as a system

Better coordination of care, including between mental and physical health, and better transitions between different services, such as between child to adult services, supported by information sharing which we will strive to make a practical reality for staff in their work.

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

Empower and resource local communities and voluntary organisations to assist with case finding and linking people through to appropriate care. Increase support for prevention and self-management, de-medicalising and destigmatising day to day support for long term conditions through social prescribing, increasing access to emotional and psychological support and widening peer support.

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

More intelligent identification of those with long term conditions or risk factors using population health management data and tools to support primary prevention which includes enabling earlier and more proactive action particularly among 'underserved' communities where there are high levels of unmet need and greater (proportional) investment in primary care in order to lead to short-term decreases in overall health system costs.

Focusing on improving end to end pathways including secondary prevention by detecting LTCs as soon as possible to halt or slow progress, encouraging personal strategies, and implementing programmes to improve health outcomes and prevent additional long-term problems.

Support people with long term conditions who may be adversely affected by poverty, particularly with costs of prescriptions which our evidence and engagement has shown has been a key issue during the cost of living crisis.

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

What success will look like for local people

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

What success will look like as outcomes for our population

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

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

Our context and case for change

Mental health affects how we think, feel and act, and has a profound impact on our day-to-day lives. It is strongly linked with wider health outcomes and therefore improvements here impact our overall ambition to improve the lives of people living in north east London.

It is estimated that at least a fifth of north east London residents have a common mental health problem like depression or anxiety, which is higher than the England average. We are also seeing an increasing need for mental health services to support people with severe and enduring mental health problems, with some of the biggest demand pressures in children and young peoples' mental health and eating disorder services. Equally we know that people with serious mental health problems endure worse physical health outcomes.

We have made great progress over the last several years in improving our services, with thousands more residents able to access evidence-based talking therapies, children and young peoples' mental health services (including in schools), specialist mental health care during and after pregnancy, and crisis and community mental health services that are far more integrated with primary care.

Yet, the Covid-19 pandemic and cost of living pressures have brought new challenges and have exacerbated the inequalities that were already present in our population. We must be mindful of the need to support those with long-standing needs who may be hit hardest, while also working proactively and preventatively to mitigate the risks of ever-greater numbers of people developing mental health conditions.

We still have further to go to ensure that people of all ages with mental and physical health conditions, including carers and people with dementia, get support in the areas that matter most to them, as early as possible. However, through honest and open conversations about equity, leadership, and representation with a diverse group of partners, we are beginning to think in a profoundly different way about how we can improve the quality of life of people with mental health needs in north east London.

Key messages we heard through our engagement

What matters to me is having the same experience and range of support regardless of where I live or go to school

What matters to me is challenging stigma about mental health
What matters to me is personal development and growth

What matters to me is using my lived experience to support and help others

What matters to me is accessing support in different ways that suits me and my goals, not just what is available and not when it is too late

What we need to do differently as a system

We must ensure that service users and carers are at the heart of everything that we do and that we prioritise what matters most to service users and carers, including delivering on the priorities set for us by service users and carers:

- **Putting what matters to service users and carers front and centre** so that people with lived experience of mental health conditions have an improved quality of life, with joined-up support around the social determinants of health
- **Enabling and supporting lived experience leadership** at every level in the system so that service users and carers are equally valued for their leadership skills and experience as clinicians, commissioners and other professionals
- **Embedding and standardising our approach to peer support across north east London** so that it is valued and respected as a profession in its own right, and forms part of the multi-disciplinary team within clinical teams and services
- **Improving cultural awareness and cultural competence** across north east London so that people with protected characteristics feel they are seen as individuals, and that staff are not making assumptions about them based on those characteristics
- **Providing more and better support to carers** so they feel better cared for themselves, more confident and able to care for others, and are valued for the knowledge and insights they can bring
- **Improving peoples' experience of accessing mental health services**, including people's first contact with mental health services, reducing inequality of access and improving the quality of communication and support during key points of transition
- **Understand and act upon local priorities for mental health,** through data and engagement with communities to understand the needs, assets, wishes and aspirations of our borough populations, and the unmet needs and inequalities facing specific groups

We must also ensure that mental health is everybody's business, for both children and young people and adults, whether this is through how we work together to tackle the wider determinants of health, or how we develop more integrated approaches to assessment, treatment and support for people with or at risk of mental and physical health problems.

We must innovate to improve outcomes and access to mental health services, including in particular where there are communities that are not accessing services as we would wish.

What success will look like for local people

Our draft success factors, developed with service users and carers, include the following (more detailed statements are being finalised with children and young people and adults):

- What matters to me is having the same experience and range of support regardless of where I live or go to school
- What matters to me is challenging stigma about mental health
- What matters to me is personal development and growth
- What matters to me is using my lived experience to support and help others
- What matters to me is accessing support in different ways that suits me and my goals, not just what is available and not when it is too late.

What success will look like as outcomes for our population

- Service users and carers are active and equal partners in everything we do, across children and young people and adults
- Care professionals focus on what matters most to service users and carers, including quality of life
- Improved preventative mental health and wellbeing offer - across our populations, places and partners - with a focus on tackling the wider determinants of poor health
- Improved access to mental health services for all our communities, including community and crisis services
- Improved integration of mental and physical health care, and with schools, social care and the voluntary sector
- Improved health and life outcomes for people with, or at risk of, mental health conditions, with particular focus on where there is inequity or unwarranted variation.

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

Our context and case for change

North east London has almost one hundred thousand staff working in health and care, with over 4,000 in general practice, 46,000 in social care, and around 49,000 within our trusts. Our workforce is the heart of our system and plays a central role in improving population health and care. Equally we have a growing population with a high proportion of working age people - we know that work is good for health and there is an opportunity for us to improve health in our local population and contribute to the local economy by upskilling and employing more local people into health and care roles within our system.

Alongside our paid workforce, our thousands of informal carers play a pivotal role in supporting family and friends in their care, including enabling them to live independently. Analysis undertaken by Healthwatch shows inequalities of experiences for carers who have poor experiences in accessing long term conditions (51%) and mental health services (70%), between 61% and 73% did not feel involved and supported.

Our employed workforce has grown by 1,840 people in the last year. Investment in primary care workforce has seen numbers grow by 3.7% in the last year, as well as a growth in training places for GPs. Retention and growth are a key part of all our workforce plans but we still have a number of challenges to overcome. We have an annual staff turnover rate of 23% and a high number of vacancies which places an additional burden on exiting staff as well as potentially impacting access to services. We have also heard from staff that burnout has been a growing problem, particularly since the COVID-19 pandemic. The interplay of increased workload and stress due to the pandemic is still having an effect. Sickness rates for north east London were higher than the national average of 4%, at 4.9%. Although we have the second lowest sickness rate in London, we know that mental health issues are the second highest reason for sickness, behind musculoskeletal problems.

To achieve our ambitions as an integrated care system we need to ensure that our workforce has access to the right support to develop the skills they need to deliver health and care services today as well as the skills to adapt to new ways of working, and potentially new roles in the future. Our workforce is critical to transforming and delivering the new models of care we will need to meet rising demand from a population that is growing rapidly with ever more complex health and care needs.

Underpinning this we will work to strengthen the behaviours and values that support greater integration, collaboration, and trust across teams, services, organisations and sectors.

Key messages we heard through our engagement

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

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

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

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

I want the informal care I provide valued and supported

What we need to do differently as a system

Work together to employ more local people contributing to the local economy by upskilling and employing local people particularly those who are unemployed or at risk of unemployment which a range of routes into jobs including apprenticeships. Also invest in growing our own workforce from within, creating a consistent pipeline in partnership with our education institutions, and utilising system-wide approaches for all sectors.

Ensure we have efficient, streamlined, and accessible recruitment processes, promoting diversity and ensuring that under-represented groups have the opportunity to be employed in our services.

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

We commit to becoming a Living Wage system adopting the London Living Wage across north East London.

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

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

Implement and continue to develop our new ICS clinical and care professional leadership model which will increase diversity and inclusion, and support development of current and future leaders for the system working hand in hand with local people.

Develop, recognise and celebrate our social care and voluntary workforce, prioritising specific retention programmes, ensuring that they have support when needed and feel valued equally for the contribution they make.

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

What success will look like for our people

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

What success will look like as outcomes for our people

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

Securing the foundations of our system

Enabling infrastructure supporting integration

Infrastructure is defined as the individuals, facilities, and buildings required to deliver world-class care. A NEL Infrastructure Plan spanning the NHS, social care, and public health is required to ensure our staff have access to high quality facilities and can utilise growing technologies such as genomics and Artificial Intelligence (AI), to deliver better care and empower local people to manage their own health. This will be increasingly important in the context of demand that is set to increase significantly from already challenging levels due to NEL's unprecedented population growth, and ageing population with more complex health needs.

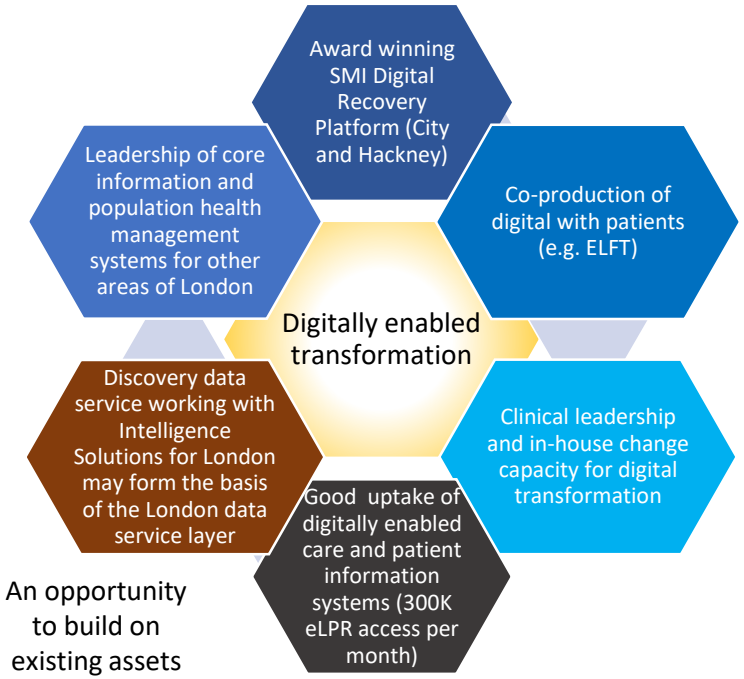
Physical infrastructure

Decades of austerity has led to funding not keeping pace with rising demand in both building capacity and essential maintenance. This coupled with a fragmented national approach to funding NHS buildings and infrastructure has led to capacity constraints across our system and a backlog maintenance adjusted sum of over c.£650 million. This is over 7 times higher than NEL's annual capital departmental expenditure limit or 'CDEL' which was £84m in 2022. In future we will develop a new, strategic approach to planning and improving our physical infrastructure by creating long-term assets that support the delivery of world-class care, promote quicker recovery and better enable staff to care for patients using the latest equipment and technology.

As part of this we are planning significant investment in our critical infrastructure including a full redevelopment of the **Whipps Cross hospital site** and a new £40m integrated health and wellbeing hub planned at **St George's in Havering,** bringing health and care partners across the borough together to deliver a new integrated model of patient focused care, opening in 2024. We are working closely with local authority partners to ensure health and care investment and capacity is present in all new regeneration areas to enhance and increase capacity in front line care for new and existing local people.

Digital infrastructure and innovation

As technology continues to develop, digital transformation will enable people to improve and manage their own health, tackling rising demand, integrating services, empowering our staff and lessening the impact of these services on the environment. Our work will focus on connecting systems together, minimising the number of different systems in use and utilising the huge amount of data available to improve care at a personal and population level.



We will build on the existing London Care Records programme to connect patient records in real-time across our provider partners to support direct care. This will mean that health and care professionals can access information from general practice, acute hospitals, mental health providers and social care in order to provide the best, personalised support for an individual. By fully implementing London Care Records across all partners we will deliver improved, joined up and better care for local people by enabling quicker and safer decisions. We will ensure that appropriate data held by NHS organisations and our local authority partners can be shared and linked to support better health and care outcomes for our local population. We will enable local people to have access to their records and to access remote care and advice. In future local people will need to tell their story only once across their health and care journey because all practitioners will have access to the same information.

Digital exclusion

Reducing digital exclusion is an essential component of our work to ensure we do not exacerbate health inequalities as we extend the range of services available digitally. We will reduce the number of local people and staff who experience digital exclusion by improving digital skills, connectivity and accessibility across our population as well as ensuring that alternative, in person, options are available for those who do not use digital services. We will monitor the access, experience and outcomes of different groups to digital and alternative service offers to ensure equity or access, experience and outcomes.

Maximising value from the money we spend and improving sustainability

As a health and care system we **spend over £4bn** every year on our population. We must ensure that money is spent as effectively as possible to meet the needs of our communities. We have a growing and ageing population which, over time, will have different needs to the people we serve today. This means that we will need to resource existing care services which are currently facing challenges in relation to demand, as well as investing in adapting our services for future needs and increasing our investment in prevention.

Collective stewardship - to meet the needs of our partnership, we are changing how money flows around the system. We are giving our partners a much greater say in how money is spent and are working together to consider the health and wellbeing of local people holistically. That means partners (such as trusts, primary care networks and local authorities) are taking **collective stewardship of the money we are spending on our population** and considering what we could change to improve population health and care outcomes. Reducing inequalities in the health and care outcomes of local people is a priority for the system and our financial regime will support this by **targeting additional funding towards those areas and populations with the worst outcomes**, and ensuring that **all local people can access core services**, whichever part of north east London they live in. We will also build on current arrangements for pooling resources between partners (under section 75 arrangements), and look to expand these to cover the full set of local and system outcomes, including wider partners and enabling more integrated care.

Investing in prevention and innovation - we will increase, over time, the proportion of our budget that is spent on prevention (both primary and secondary) and earlier intervention, to ensure local people are kept healthier for longer and, in turn, reducing the need for more specialist services. To support the transformation of health and care services, **we will set aside some of the funding we receive to specifically fund improvements that support sustainability**, such as technology which improves health and care outcomes for our population. Alongside this, we will **improve our use of evaluation, to build our understanding of how money is spent and what outcomes we are achieving** for our people and communities. We will use our shared data to develop the evidence base in support of continuously improving delivery and outcomes.

Improving sustainability of our system and core services - over half of our health and care budget (or approximately £2.6bn) is spent on secondary care provided by our trusts. We will continue to look for **productivity improvements** – in particular within our trusts – to ensure that we are maximising value for money, including reducing waste and avoidable spend, such as over-reliance on agency staff. The pandemic, cost of living pressures and rising inflation have added to system pressures and left us financially and operationally challenged as a system. Our trusts, with their substantial cost bases reflecting their large estates and workforces, have borne much of the financial pressure. We will **continue to support the financial sustainability of our trusts** and also the **sustainability of the key services** they deliver with a current focus on urgent and emergency care, and addressing waiting times and equity of access for planned care. Actions we will take to reduce avoidable demand for acute services include supporting greater streamlining and harmonisation of services and developing more **comprehensive multidisciplinary provision in neighbourhoods.** This work is already underway as part of the our implementation of the recent Fuller Review recommendations.

A relentless focus on equity

In addition to our focus on tackling ***health inequalities*** as described above, we are working to tackle ***unwarranted variation*** across all our services, ensuring that ***equity is embedded*** across all of our strategies, plans and ways of working. This means -

Equitable core service offer – we commit to understanding and implementing a core set of services particularly in community health and mental health services across NEL as well as addressing variation in local policies to ensure consistency and equity across our geography.

Place based partnerships and provider collaboratives – will have a detailed understanding of equity and unwarranted variation in relation to their health and care services and are improving equity of access, experience and outcomes for underserved groups working hand-in-hand with local people and communities.

Investment – we are establishing an equitable funding framework to allocate resources in ways that do not exacerbate but reduce health inequalities. Resources enable a baseline of consistent provision to support equity in outcomes, whilst at the same time being proportionate to need across groups and places.

Workforce – we will support inclusion within our current workforce staff and take action to develop a workforce that is reflective of the local community. This includes improving equity in recruitment, development, management and disciplinary processes, more diverse boards and senior management teams, and championing anti-racism across all parts of the system.

Quality improvement, safety and transformation – we will equip all staff (clinical and care professional and managerial) working on quality improvement (QI), patient safety, safeguarding and transformation with an understanding of health inequalities and equity through training, fellowships and shared learning. Rapidly scaling what works across the system.

Evaluating equity impacts – we will set out a requirement for evaluation of the health inequalities impacts of any changes through the use of the EQuality impact assessment process, developing understanding of how equity considerations can be continually built into service design and improvement.

Data and digital – we will strengthen our understanding and focus on population health and inequalities at a granular level for different population groups and especially for underserved people and communities, including through development of *Population Health Management* across the system.

Anchor institutions – we will address the wider determinants of health and reduce health inequalities, through providing employment for local people who are furthest from the labour market, increasing social value in procurement practices, and tackling climate action for a greener, healthier future.

Where we go from here

The three core elements of our interim strategy set a clear direction for the system ahead of the 23/24 planning round, and looking to the future will be the basis for our longer term planning as a system…

……Our 6 crosscutting themes underpinning our new approach as an ICS

……Our four system priorities for improving outcomes and tackling health inequalities

……Our key areas for securing the foundations of our system

As well as influencing the annual planning round for the NHS, the integrated care strategy is the 'umbrella' for the full range of strategies and plans across the partnership including local joint health and wellbeing plans, plans developed by provider collaboratives, and other system wide plans e.g. relating to people, sustainability, quality and finance.

In line with our learning system approach and partnership ethos, we are committed to continued dialogue with all parts of the system to support ongoing alignment.

While the strategy has been informed by existing insights via Healthwatch as well as feedback from local people and service users in some areas, the key messages, priorities and success measures will be tested further with local people through a 'Big Conversation' planned to take place in Spring 2023.

We will review our interim strategy in line with further guidance anticipated from the Department of Health and Social Care in June 2023.

We will also develop the success measures outlined in the strategy further to enable the partnership to track progress over time, ensuring we are making a measurable difference with and for the people of north east London.

Annex 1 – strategic alignment with local health and wellbeing priorities and provider collaboratives

Hackney

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

Redbridge

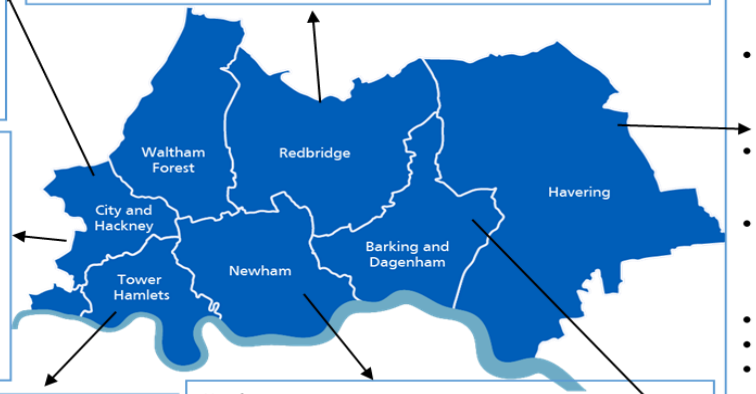
- Achieving the best start in life
- Diabetes prevention and management
- Mental wellbeing
- Cancer survival
- Living well in a decent home you can afford to live in
- End of life care

Havering

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

City of London

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



Tower Hamlets

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

Newham

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

Barking and Dagenham

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

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

Provider collaboratives

- **Community collaborative -** The Community Health Collaborative brings together NHS Community Health Services to focus on population health needs that are best supported at an ICS or multi-borough level including working with local authority partners to achieve common standards and outcomes, reduce unwarranted variations, address inequalities in health outcomes, and improve access and experience of services.
- **Mental Health, Learning Disability and Autism Collaborative** - In North East London, the Integrated Care Board, East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT) have come together to form the Mental Health, Learning Disability and Autism Collaborative. Our aim is to work together to improve outcomes, quality, value and equity for people with, or at risk of, mental health problems, learning disabilities and autism in North East London.
- **Primary Care Collaborative** - This brings strategic primary care leadership together 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 and will involve close working across the whole system with partners in place based partnerships and provider collaborative.
- **Voluntary, community and social enterprise (VCSE) alliances** - The VCSE alliance brings specialist expertise and fresh perspectives to public service delivery, and is particularly well placed to support people with complex and multiple needs and finding creative ways to improve outcomes for groups with the poorest health.
- **Acute provider collaborative -** Our acute provider collaborative is comprised of the three acute trusts across NEL. The organisations have agreed to work together across six clinical pathways (planned care, critical care, maternity, urgent and emergency care, cancer, and babies, children and young people) and three cross-cutting strategic themes (clinical strategy, research and specialised services).

NHS North East London ICB board

25 January 2023

Title of report	Joint Forward Plan – Update
Author	Saem Ahmed, Head of planning and performance, NHS North East London
Presented by	Johanna Moss, Chief Strategy and Transformation Officer, NHS North East London
Contact for further information	saem.ahmed@nhs.net
Executive summary	• The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England, and their partner NHS trusts and foundation trusts, to produce and publish a Joint Forward Plan (JFP). As well as setting out how the ICB intends to meet the health needs of the population within its area, the JFP is expected to be a delivery plan for the integrated care strategy of the local Integrated Care Partnership (ICP) and relevant joint local health and wellbeing strategies (JLHWSs), whilst addressing universal NHS commitments. As such, the JFP provides a bridge between the ambitions described in the integrated care strategy developed by the ICP and the detailed operational and financial requirements contained in NHS planning submissions. • Systems have significant flexibility to determine their JFP's scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. • ICBs and their partner trusts should review their JFP before the start of each financial year, by updating or confirming that it is being maintained for the next financial year. They may also revise the JFP in-year if they consider this necessary. • The purpose of the JFP is to describe how the ICB, its partner NHS trusts and foundation trusts intend to meet the physical and mental health needs of their population through arranging and/or providing NHS services addressing the four core purposes of the ICS, the universal NHS commitments and meeting the legal requirements of the guidance.
Action required	Note/Discussion
Previous reporting	NEL Integrated Care Partnership (ICP)
Next steps/ onward reporting	Further engagement and discussion through relevant ICB committees, partner meetings (e.g. meeting of local authority

	leaders/execs, NEL healthwatch group), ICP steering group and committee)
Conflicts of interest	Not applicable
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The JFP builds on the work developed through the Integrated Care Strategy which describes the four system priorities that aim to address inequalities focusing on core20plus5 (an approach to inform action to reduce healthcare inequalities at both national and system level)
Impact on finance, performance and quality	• The impacts will be worked through the development of the JFP. • The JFP legislative requirements requires the JFP to reference finance, performance and quality.
Risks	The risks to delivery against priorities is the workforce and resources available.

North East London Health & Care Partnership

NHS North East London

Briefing on Joint Forward Plan

January 2023

Saem Ahmed – Head of planning and performance

1. Introduction to the Joint Forward Plan (JFP)

- The **Health & Care Act 2022** requires each Integrated Care Board (ICB) in England, and their partner NHS trusts and foundation trusts, **to produce and publish a Joint Forward Plan (JFP).**

- The JFP covers a **five year horizon** but ICBs and their partner trusts are expected to review their JFP before the start of each financial year, by updating or confirming that it is being maintained for the next financial year. They may also revise the JFP in-year if they consider this necessary.

- Joined up planning is required to address multi-year challenges such as:
    - **Addressing current operational priorities** and pressures as well as **actions that will support sustainable services going forward**, in line with the fore core purposes of the ICS.
    - Supporting **delivery of NHS commitments (performance measures) including LTP commitments, finance, workforce, activity measures and local priorities** described in the integrated care strategy and joint health and wellbeing strategies.
    - Set out how the resources of the whole system will be to effectively organise and deploy to deliver these priorities.

- The purpose of the JFP is to describe how the ICB, its partner NHS trusts and foundation trusts intend to meet the **physical and mental health needs of their population** through arranging and/or providing NHS services addressing the **four core purposes of the ICS, the universal NHS commitments and meeting the legal requirements of the guidance.**

2. NEL's ambition for the JFP

- Systems have **significant flexibility to determine their JFP's scope** as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts.
- National guidance emphasises the need for JFPs to address NHS universal commitments, legislative requirements of NHS providers and the ICB's four core purposes (see Appendix C).
- Our intent is that the NEL JFP forms the **delivery plan for our Integrated Care Partnership (ICP) strategy** and enables us to plan in the medium term for health and care services across NEL.
- We will ensure that our JFP works across health, local authorities and wider partners and is connected to local Health and Wellbeing strategies as well as Joint Strategic Needs Assessments.
- We will adopt a similar approach to the development of our ICP strategy, establishing a task and finish group with membership from across health and local authority partners as well as local Place Based Partnerships and Health and Wellbeing Boards.
- Our JFP will include;
    - Description of our current provider and service landscape across health and care
    - Description of how the needs of our population are changing and the challenges this creates
    - Summary of our ICP strategy and ambitions
    - Description of our transformation plans, with detailed plans for 2023/24
    - Description of how we will work together through our Place Based Partnerships and Provider Collaboratives to deliver our ambitions

3. Key principles in development of the JFP

National guidance summarises three key principles which should be adopted in developing the JFP;

Principle 1: Fully aligned with the ambitions of the wider system partnership

- The JFP should reflect the collective ambitions of the ICB, local NHS partners, local authorities and wider system partners to meet the health needs of the ICB's population.
- The JFP should describe delivery of ambitions articulated in the integrated care strategy (these may be in initial or outline form)

Principle 2: Supports subsidiarity by building on existing local strategies and plans as well as reflecting universal NHS commitments

- The JFP should be a single, cohesive plan. It should address both system and place priorities and universal NHS commitments.
- The plan should respect the principle of subsidiarity and be built from existing delivery plans at system or place (where these exist). The JFP is not intended to transfer planning or delivery activity to system level where this is best delivered at place but could be used to summarise or synthesise place level plans.

Principle 3: Delivery-focused, including specific objectives, trajectories and milestones as appropriate

- JFPs should be delivery plans with well-defined, measurable goals, annual milestones and trajectories. These should align with the detailed operational plans of the ICB and NHS provider partners and relevant plans of the local authorities in the ICS area.
- Plans should be appropriately ambitious and deliverable. As published plans, ICB and partner trusts should expect to be held to account for their delivery. ICB and NHS trust and foundation trust annual reports should describe progress in delivery.

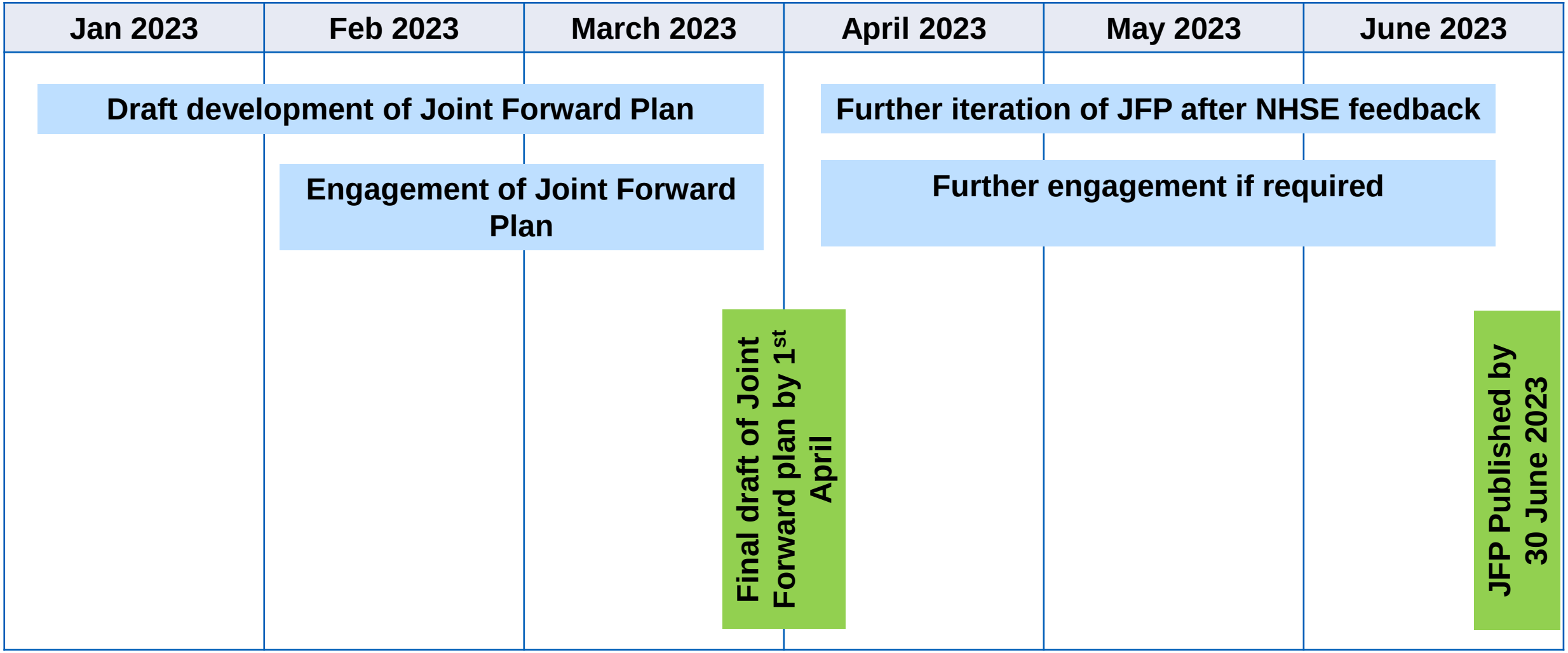
4. Developing our plan

- **Close engagement with system partners is essential** to the development of the JFP and we will work with all our partners including;
  - the ICP (ensuring this also provides the perspective of social care providers)
  - primary care providers
  - local authorities and HWBs
  - other ICBs in respect of providers whose operating boundary spans multiple ICSs
  - NHS collaboratives, networks and alliances
  - the voluntary, community and social enterprise sector
  - people and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives

- As the JFP will build on and **reflect existing JSNAs, JLHWSs and NHS delivery plans** we **do not anticipate its development will require full formal public consultation, unless a significant reconfiguration** or major service change is proposed.

- We will use previous resident and patient engagement, particularly the recent engagement to develop our ICP strategy, as well as our planned Big Conversation during the Spring to inform the development of our JFP.

5. Timeline and deadline



North East London Health & Care Partnership

NHS North East London

Appendices

A: Relationship between strategy and plans

Transformation or addressing inequalities and service redesign

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

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

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

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

Impact

Activity and performance trajectories

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

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

B: Relationship of the JFP with other strategies and plans

Relationship	Progress update
NHS mandate The government's mandate to NHS England sets out our objectives, revenue and capital resource limits. This informs both our guidance on priorities and planning requirements.	• NHS priorities and operational guidance published on 23 December 2022. • NEL is currently in the planning round for this through the system Operational Planning coordination group**.**
Integrated care strategy Our strategy provides a framework for our partnership, outlining a clear set of priorities, core themes for working differently and some key foundations for our system.	• Draft strategy approved by the Integrated Care Partnership on 11 January 2023. • Engagement with the wider system ongoing.
Capital Plans Before the start of each financial year, ICBs and their partner trusts must set out their planned capital resource use.	• Awaiting further guidance on this. • Further guidance to be published nationally on development of capital plans.
Joint strategic needs assessments (JSNA) JSNAs, developed by each responsible local authority and its partner ICBs, assess needs that can be met or be affected by the responsible local authority, its partner ICBs or NHS England.	• Local JSNA's have informed our Integrated Care Strategy and the development of our four system priorities.
Joint local health and wellbeing strategies Each responsible local authority and its partner ICBs will have produced a JLHWs.	• Health and Wellbeing strategies have informed our Integrated Care Strategy and we have highlighted and acknowledged the place based priorities, and identified where there are relationships between the four system priorities and the place based priorities.

C: Universal NHS requirements, core purposes and legal requirements

NHS universal commitments

	Area	Objective
Recovering our core services and improving productivity	Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

Four core purposes

- **Improving outcomes** in population health and health care
- **Tackling inequalities** in outcomes, experience and access
- Enhancing **productivity and value for money**
- Helping the NHS support **broader social and economic development**

Legislative requirement

- **Describing the health services** for which the ICB proposes to make arrangements
- Duty to **promote integration**
- Duty to have **regard to wider effect of decisions**
- Financial duties
- **Implementing any JLHWS**
- Duty to **improve quality of services**
- Duty to **reduce inequalities**
- Duty to **promote involvement of each patient and the public**
- Duty to **patient choice**
- Duty to **obtain appropriate advice**
- Duty to **promote innovation**
- Duty in respect of **research**
- Duty to promote **education and training**
- Duty as to **climate change**, etc
- Addressing the particular **needs of children and young persons**
- Addressing the particular needs of **victims of abuse**

NHS North East London ICB board

25 January 2023

Title of report	Deep Dive into Primary Care
Author	Sarah See - Managing Director of Primary Care
Presented by	Johanna Moss - Chief Strategy and Transformation Officer
Contact for further information	Sarah See, Managing Director of Primary Care sarahsee@nhs.net
Executive summary	The challenges facing general practice across north east London (NEL) are complex and enduring: recruitment and retention of a sustainable workforce; variation in access coupled with a mobile population with significant health problems, compounded by the wider determinants of health. Working with our partners across the integrated care system (ICS) will strengthen the general practice infrastructure with opportunities to employ a workforce that has the right skill mix to meet the need of local communities within a neighbourhood. The Fuller Review Programme also provides us with the opportunity to streamline urgent same day access; help people stay well longer; and provide proactive, personalised care via multi-disciplinary working. This report highlights the key issues facing general practice and recommends a number of questions for discussion to inform primary care strategy and future planning
Action required	Discussion
Previous reporting	The content within the deep dive report has been discussed at the General Practice Provider Group
Next steps/ onward reporting	The output and outcomes from this report will be managed through primary care governance including the Primary Care Collaborative and shared with the general practice provider group which focuses on delivery and learning from best practice.
Conflicts of interest	N/A
Strategic fit	This report aligns to all of the ICS aims • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	This report highlights the challenges and issues that local people experience with significant variations in clinical quality and the range of services available to residents across NEL.

	It also highlights the complexity of managing primary care services through a system of 276 small independent providers and 47 networks all with different business and workforce models leads to variation in quality and performance that impacts upon the population.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report other than those described in the examples given within the report.
Risks	The key risks associated with this report are included in the risk register including • Ability to recruit and retain the workforce • Risk that practices will not have the capacity to put in place interventions to address access. • Capacity within General Practice to rapidly prioritise practical interventions to improve patient experience of access and staff workload • Risk of lack of funding to support the development of general practice infrastructure Estates/Digital

North East London Health & Care Partnership

NHS North East London

ICB Board – Deep Dive into Primary Care

NORTH EAST LONDON HEALTH AND CARE PARTNERSHIP

25 January 2023

For discussion:

The challenges facing general practice in NEL are complex and enduring: workforce; variation in access; continuity of care in a high-need, mobile population with significant health problems compounded by the wider determinants of health.

- How can we use the opportunities of working as an ICP to address the challenges facing general practice?
- How should we engage as a system with our residents, general practice colleagues and system partners to co-design and agree what good access looks like?
- How do we best engage with our residents to generate a better understanding of the new roles working within a primary care setting?
- How do we embed our primary care workforce plans with the ICB's workforce programme to ensure synergy and maximise opportunities for growing the general practice/PCN workforce?
- It's difficult to drive sustainable change on the basis of short-term, non-recurrent funding. In terms of the range of same day access services in a general practice/primary care setting, and in the context of increasing demand, how do we best provide stability to deliver medium/long term change?

North East London Health & Care Partnership

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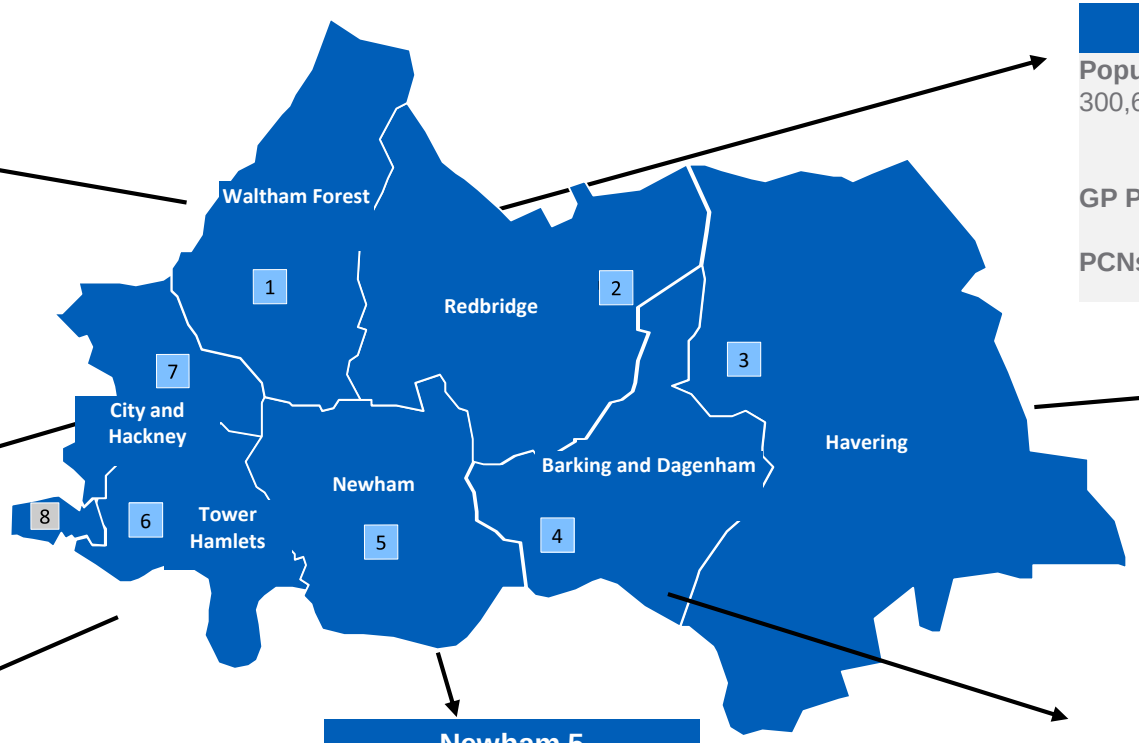
Overview of the primary care landscape

NEL overview of service provision

NEL is currently made up of eight local authority areas covered by seven places, 276 GP practices and 47 primary care networks (PCNs).



Waltham Forest 1

Population: 276,000

Major Hospitals: Whipps Cross

GP Practices: 39

PCNs: 7

Redbridge 2

Population: 300,600

Major Hospitals: King George Hospital

GP Practices: 42

PCNs: 6

City and Hackney 7 / 8

Population: 277,000

Major Hospitals: Homerton Hospital + St Bartholomew's

GP Practices: 40

PCNs: 8

Havering 3

Population: 250,500

Major Hospitals: Queen's Hospital

GP Practices: 41

PCNs: 4

Tower Hamlets 6

Population: 296,300

Major Hospitals Royal London

GP Practices:35

PCNs: 7

Newham 5

Population: 338,600

Major Hospitals Newham University Hospital

GP Practices: 46

PCNs: 9

Barking and Dagenham 4

Population: 206,700

Major Hospitals: Nil

GP Practices: 33

PCNs: 6

North East London Health & Care Partnership

NHS North East London

Primary Care - challenges and opportunities

The challenges facing general practice are complex and enduring:

- **A mobile and growing population:** in some neighbourhoods patient 'turnover' is 30% which means prevention activity (such as calling patients for immunisation and screening) is harder to achieve. There will be an extra 250,000 people living in NEL in ten years' time, creating more demand on the current primary care landscape
- **Complexity and acuity:** high prevalence of some long-term conditions in our population means people are living longer with more complex needs
- **Diversity:** More than half (53%) of NEL's population identify as Black, Asian or from an ethnic minority requiring us to understand and accommodate different cultural needs, overcome language barriers and signpost on how best to use the NHS
- **Scale of deprivation:** we have significant areas of deprivation which has an impact on the wider determinants of health, increasing demand for primary care services
- **Workforce capacity and capability:** most boroughs in NEL are below London and national averages for GP and practice nurse to patient ratios. We need to recruit, retain, and enable a broad skill mix of staff
- **Access and patient satisfaction:** despite appointment numbers increasing since 2019 (by 17%) patient demand is outstripping capacity, and patient satisfaction rates have reduced. The majority of patients remain satisfied with their care, although the GP Patient Survey results indicate that this has also reduced from 78.6% in 2021 to 70.5% in 2022. City & Hackney showed the least variation, with most practices showing above average positive response rates
- **Elective backlog:** across NEL we have a significant number of residents waiting for elective care which is generating additional demand across the system including in urgent care and primary care pathways
- **Inequity of provision:** there are significant variations in clinical quality and the range of services available to residents across NEL
- **Variation within the provider landscape:** general practice operates as a system of small, independent providers and each of the 276 practices across NEL has different business and workforce model. This leads to variation in quality, performance, training, education, recruitment and retention. Not all PCNs are aligned to local authority neighbourhoods
- **Inequity in funding:** the national formula for funding general practice does not fully factor in deprivation and population health needs
- **Costs of living:** the ongoing cost of living crisis may impact on the viability of some GP providers, and the retention of staff working at practices

The opportunities for primary care

- **Workforce:** the Additional Roles Reimbursement Scheme (which funds 12 new roles including social prescribers) enables PCNs to develop a more diverse skill mix working at a neighbourhood level
- **Anchor institutions:** primary care services are, by their nature, deeply embedded within our neighbourhoods. This creates opportunities to train and employ our residents to work in a primary care setting and would enable us to further diversify the skill mix of our workforce
- **Our partners and partnerships:** the ICB affords us the opportunity to support general practice by developing a comprehensive neighbourhood model to meet the needs of local communities
- **The Fuller Review Programme:** provides us with the opportunity to streamline urgent same day access; help people stay well longer; and provide proactive, personalised care via multi-disciplinary working
- **Access:** during the pandemic teams across primary care developed new, innovative ways of accessing general practice. We now have an opportunity to work with our residents, providers and wider system partners to co-design a new definition of and model for accessing primary care
- **Digital solutions:** innovations in technology will enable new opportunities for residents to self-care and establish different ways of communicating with general practice
- **Infrastructure:** new investment in the estate across NEL is providing the necessary space to bring all health and care providers together to create community hubs to support multi-disciplinary working
- **Population health management:** using risk stratification to support prevention and tackle health inequalities
- **Primary care collaborative:** will enable collaboration across the wider primary care family and with other provider collaboratives, enabling integrated commissioning and budgets
- **NEL hosting of Dental, Optometry and Community Pharmacy contracts:** (on behalf of London) will enable the ICB to bring the primary care family together to develop new services at a neighbourhood level

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Implementing the Fuller Review in NEL

Our approach to the Fuller Review

The Fuller Review created a new vision and case for change for integrated primary care, recommending system leadership at every level to support and enable place-based partnerships to deliver change in the way primary and community care services are delivered at neighbourhood level. It emphasises the need to integrate primary care, improve access, experience and outcomes centred around three essential offers of:

- **Streamlining access to care and advice**
- **Providing more proactive, personalised care with support from a multidisciplinary team of professionals** and
-
- **Helping people to stay well for longer.**

In response to the Fuller Review, we have developed four core workstreams led by SROs from across the system.

Workstreams	Streamlining Urgent Primary Care	Continuity of Care	Enablers – People	Enablers – Infrastructure
Projects	• Enhanced Access • Integrated urgent primary care e.g. NHS 111 • Same day access to urgent care services	• Prevention • Long Term Conditions • Integrated neighbourhood teams development	• Workforce • Clinical Leadership • Organisational development	• Digital • Data • Estates • Interoperability • Telephony

Continuity of care workstream

Examples of innovation supporting the Neighbourhood Development Model in NEL:

- **Anticipatory Care in City and Hackney**
- **Newham Frailty and Anticipatory Care Pilot – Built in Partnership**
- **Local Leads Model in Barking and Dagenham**
- **Gardening for Health in Tower Hamlets**

What *do we do well for this workstream in NEL?*

- Ways of working: good system leadership; innovative working; partnership engagement; excellent, dedicated staff; range of community assets
- Population health management - understanding our population.

How do we add value to the good things that are already in place, build on them and learn from each other?

- Sharing information, learning, resources, good practice
- Work more closely with residents
- Build in organisational development to enable further integration across teams

Where are the gaps, how do we understand them, how do we go about closing them?

- Workforce, infrastructure and consistent ability to have meaningful conversations with our residents. Establishing mature matrix working across ICB team and various fora is essential
- Agreeing priorities – identify a few key projects that we can continue to develop/create some quick wins; build on work underway.

Enablers: infrastructure (digital and estates) workstream

Examples of innovation supporting digital & estates workstream in NEL:

- **E4 Waltham Forest PCN hubs**
- **Loxford community space**

What works well?

- Use of infrastructure to deliver integration of services both digitally and physically eg Loxford community space
- Ways of Working: good system leadership; innovative working eg patient centric room bookings for MDT teams; Staff feel empowered; Strong PCN infrastructure plans.

What needs to be fixed/improved?

- Sharing learning 'what works' across NEL eg via intranet
- A known ICB contact is needed
- Standardisation of information “One size fits all” not the right approach
- Enhanced access – need more guidance, gold standard, PCN workshop
- Better use of Federations eg could work be outsourced?
- More workshops, intranet usage and conversations.

What can we accelerate?

- Easy access to resource and ICB leadership
- Better sharing of information including problems that others have resolved, good practice and expertise
- NEL user group/forum for both digital and estates
- Create a space where clinicians can be involved in finding solutions – how do we fund?

Enablers: people workstream

Examples of innovation supporting the People workstream in NEL:

- **Working together with primary and voluntary care to support the mental health needs of residents across ELFT**
- **Physicians Associate - opportunities and challenges of working in her role**
- **Developing workforce models and teams around the needs of residents**

Emerging thinking:

- It will be important to create a shared sense of vision, purpose and value within each neighbourhood, and we need to acknowledge that different organisations have different cultures around risk and help foster a shared culture that puts the needs of residents first.
- We need to provide space and opportunities to allow relationships to develop.
- Creating homes or “roots” at a neighbourhood level will foster a sense of belonging.
- It is important to value and provide clearly outlined career paths for non clinical roles such as Physicians Associates, ARRS and Practice Managers.
- It is essential to provide an enabling environment for working across organisations.This includes ensuring interoperability of systems, understanding barriers such as training needs and building mechanisms for sharing financial risks.
- Leaders should allow risk taking in a measured way, encouraging a QI approach that allows for testing, learning and recalibrating thinking of improvement as a shared approach.
- There is an opportunity to create microsystems working towards a shared goal as a pilot to extend outwards.

Urgent and emergency care workstream

Examples of innovation supporting the Urgent and Emergency Care workstream in NEL:

- **Healthspot** - innovative and integrated holistic healthcare provision for and with young people locally across Tower Hamlets.
- **Remote Emergency Access Coordination Hub (REACH)** - joined up care coordination from multi-disciplinary teams ensuring no decisions are made in isolation.

What works well?

- Access to Urgent Care and increased diversity in the mode of the appointments in Primary Care eg enhanced hubs and GP appointments
- Partnership working: B&D health inequalities work with voluntary sector around patient education; 35000 CPCS appointments moved out of general practice and into pharmacy; REACH, openness for provider opportunities
- Ways of working: good clinical leadership; different roles and ways of working that can support access to and for specific groups, listening to patient needs and wants.

What can we accelerate?

- Joint working and interface between community services eg LAS/Rapid Response and the REACH service to reduce A&E attendances
- Communication and data insights between LAS, Primary, Urgent and Emergency care
- Joint ownership of solutions to on the day access and keeping this work in primary care

What can be improved?

- Patient journeys/pathways
- System literacy for GPs around Urgent Care and what is available in the community to support admission avoidance
- Further joining up of the system between individual services.

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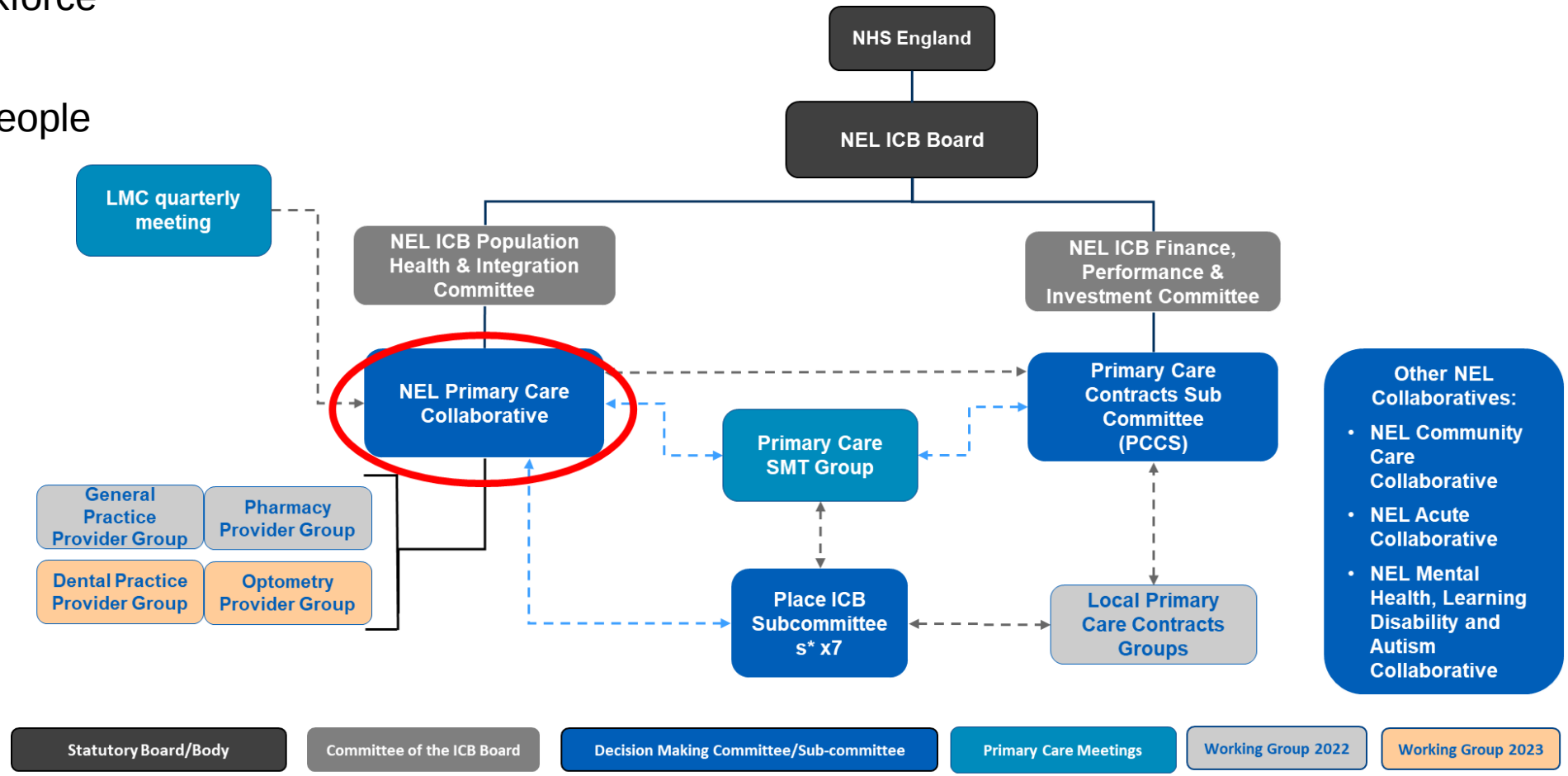
Primary Care Collaborative

Primary Care Collaborative: purpose

We will support the **ICB** in discharging its statutory functions, delivering the strategic priorities of the ICS.

We will support the **ICS** with the achievement of its ICS wide priorities:

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



Primary Care Collaborative: outputs and outcomes

We will

- Develop and agree a North East London primary care strategy to inform the contracting and transformation of general practice, pharmacy, dentistry and optometry
- Oversee the implementation and delivery of the primary care strategy and associated transformation programmes
- Reduce inequities in care provision and unwarranted variation in outcomes for patients and residents
- Provide coherent and structured clinical leadership for primary care services across North East London, working closely with place based clinical leaders and partners across other provider collaboratives
- Agree a common approach and standards where needed across primary care services
- Act as a forum for learning and sharing best practice based on robust data
- Provide a forum for other provider collaborative groups to engage with primary care services
- Support work occurring across and within the place-based partnerships to improve population health and healthcare
- Review the productivity of primary care services and ensure unwarranted variation is addressed through continuous quality improvement

General Practice's role in delivering the ICP's strategic priorities (1)

Long Term Conditions

- General practice has a core role in the prevention agenda, implementing interventions for those at risk of developing a long term condition (LTC) and supporting those living with a LTC to thrive.
- Monitoring of HbA1C and blood pressure (BP) results are two key indicators of good control for people with diabetes. In NEL both HbA1c and BP readings have shown an ongoing improvement. However, for both measures a third of the diabetic population in NEL has poorly controlled BP and HbA1c.
- Risk stratification is one way to reduce the overall risk in the population; targeting those mostly likely to experience the onset of diabetes if no intervention happens, identifying those with undiagnosed diabetes and identifying those with uncontrolled diabetes.

Children and Young People

- Keeping children protected from infectious disease is important to having a good start in life. Whilst NEL has a good and improving record on childhood immunisations, there remain significant challenges in improving uptake including vaccine hesitancy, and diverse and highly mobile population which can make contact difficult. A hyperlocal approach, with effective partnership working, may be one way to improve uptake.
- There are two national targets for childhood immunisations: the England national target is 95% and the QOF target is 90%. Only three boroughs (Havering, Tower Hamlets and Newham) are currently achieving the QOF target within the 12 months old cohort. No boroughs have recorded an immunisation rate that meets the England 95% target. The 24 months and 5 years old cohorts record lower rates of immunisations

General Practice's role in delivering the ICP's strategic priorities (2)

Mental Health

- Primary care has a proactive role to play in supporting an integrated care offer to residents with mental health conditions. Health checks are important to those living with a severe mental illness (SMI) as this cohort of people are more likely to develop physical health issues than the general population.
- The national target for health checks for people living with a SMI is 70%. As of January 2023, NEL performance is at 52% (c4290 people).

Employment and Workforce

- General Practice operates as a system of small, independent providers with variation in culture, size, funding, training and education opportunities, which create challenges in recruitment and retention.
- Improving the size and scope of the workforce, developing hyperlocal programmes to improve recruitment and retention and increasing the skill mix within General Practice can help address these challenges.
- To date, PCNs across NEL have recruited to 628 WTE posts under the PCN Additional Roles Reimbursement scheme – however there are still significant gaps in some PCNs, and retention of these roles remains problematic.

Access and patient experience

- There is no correlation seen between patient satisfaction and rate of total or face to face appointments, which suggests that increased appointment volume does not automatically result in better patient experience. It is important for the system to understand the themes around dissatisfaction which are principally related to accessing General Practice rather than the experience of care received.

North East London Health & Care Partnership

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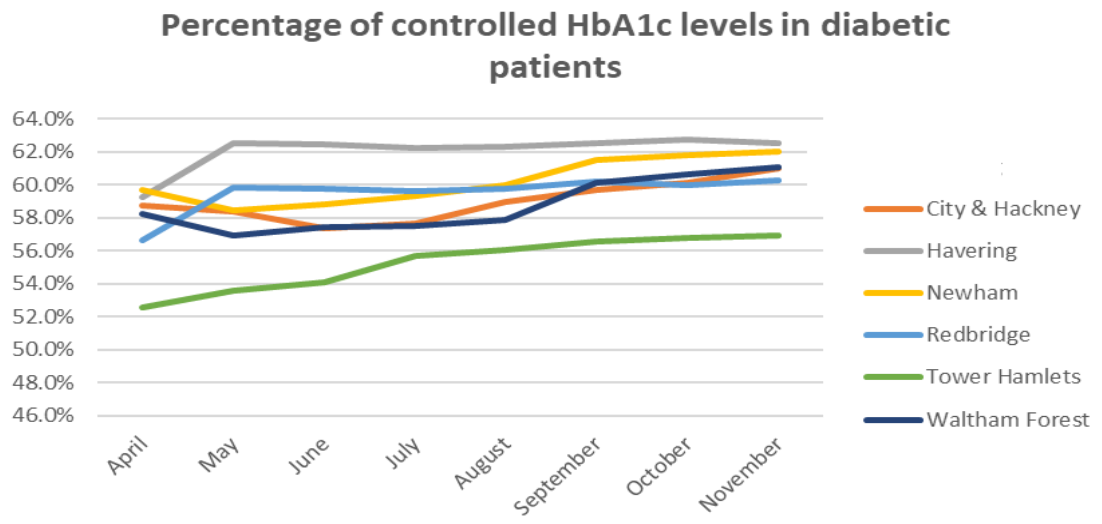
Benchmarking data - evidence

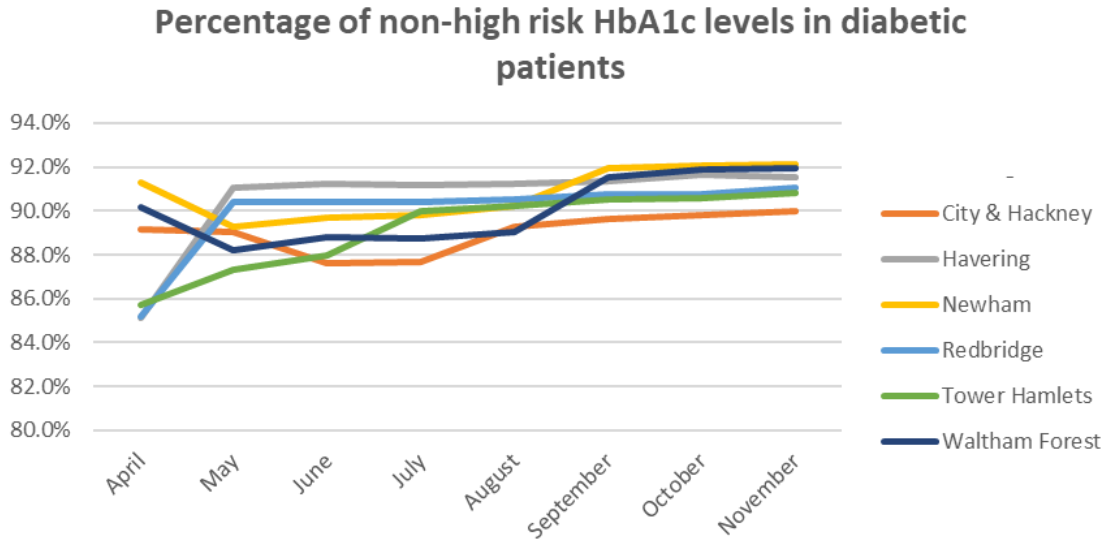
Approx. two thirds of diabetic patients have controlled HbA1C levels

- The line charts show the percentage of controlled readings in the last 8 months (of the 15 months)
- The tables show the rate of controlled and high risk readings in the last 15 months by borough as of November 2022. Monthly data is unavailable for B&D

- Controlled HBA1C levels are <=58mmol
- High risk HBA1C levels are >89mmol
- 60.3% of patients on the diabetes register, have controlled HBA1C levels meaning that more than a third are uncontrolled
- There has been an increase in the rate of controlled HbA1c readings in the last 8 months
- There has also been an increase in readings of non-high risk HbA1c
- Less than 10% of readings have been recorded as non-high risk in NEL in the last 8 months



Borough/Place	% Controlled HbA1c readings in last 15 months
Havering	62.5%
Newham	62.0%
Waltham Forest	61.1%
City & Hackney	61.0%
Redbridge	60.3%
Barking & Dagenham	57.3%
Tower Hamlets	57.0%
NEL Total	**60.3%**



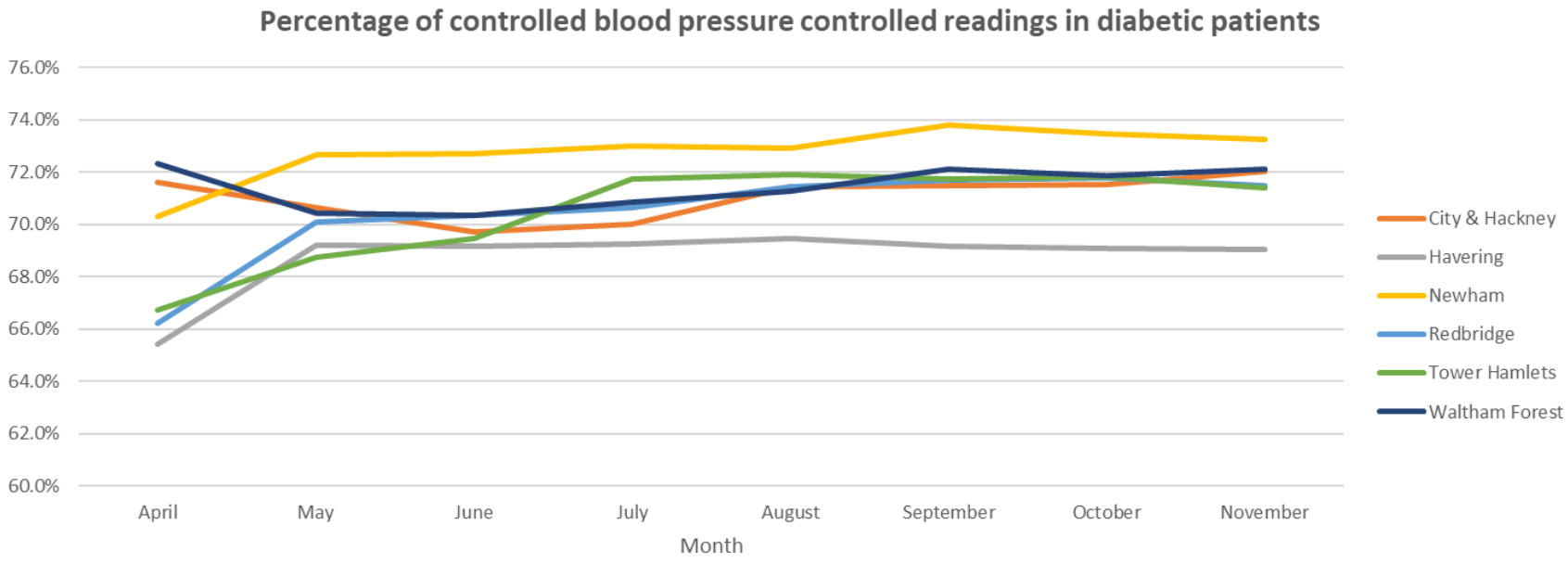
Borough/Place	% Non-high risk HbA1c readings in last 15 months
Newham	92.1%
Waltham Forest	92.0%
Havering	91.5%
Redbridge	91.1%
Tower Hamlets	90.8%
City & Hackney	90.0%
Barking and Dagenham	88.2%
NEL Total	**91.0%**

Source: Clinical Effectiveness Group (CEG)

Two thirds of diabetic patients in NEL have controlled blood pressure

- The line charts show the percentage of controlled readings in the last 8 months (of the 15 months). Monthly data is unavailable for B&D
- The tables show the rate of controlled blood pressure readings in diabetic patients in the last 15 months by borough as of November 2022

- **Controlled blood pressure readings are <=140/80mmHg**
- **Controlled blood pressure readings have increased across NEL boroughs during 2022/23**
- **In the last 15 months 128,053 readings have been recorded, of which 91,729 (71.6%) showed a controlled reading**



Borough/Place	% Controlled blood pressure in last 15 months
Newham	73.2%
Waltham Forest	72.1%
Havering	69.1
Redbridge	71.5%
Tower Hamlets	71.4%
City & Hackney	72.1%
Barking and Dagenham	70.7%
NEL Total	**71.6%**

Source: Clinical Effectiveness Group (CEG)

Overall NEL doesn’t achieve any of the children’s immunisation national targets

The majority of childhood immunisation metrics in NEL are below target

- The table shows the latest childhood immunisation rates, as of the end of 2022/23 Q2, for all immunisation rates by borough.
- At present, there are two targets:
  - **The NHS England target is 95%**
  - **The QOF target is 90%**

- **Only three boroughs (Havering, Tower Hamlets and Newham) at present are achieving the QOF target, all only within the 12m cohort**

- **No boroughs have recorded an immunisation rate that meets the England 95% target**

- **The 24 months and 5 years old cohorts record lower rates of immunisations**

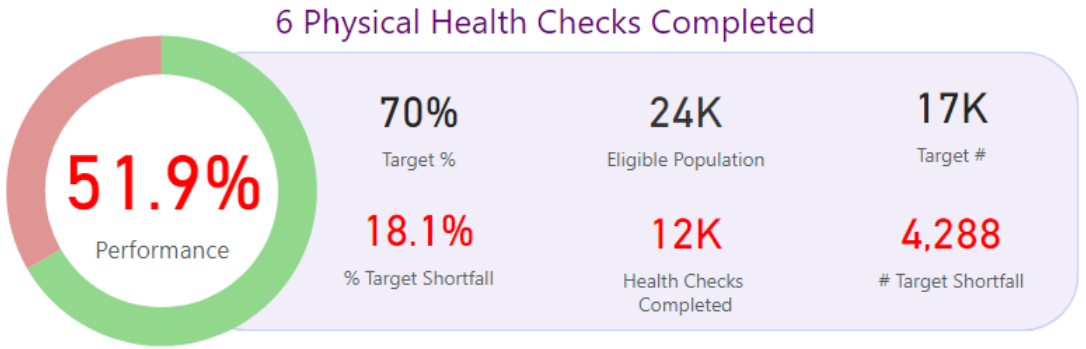
Average Immunisation Percentage Per Age Cohort				
Borough	**12 m**	**24 m**	**5 years**	**Average**
Havering	92.4%	88.3%	72.4%	**84.4%**
Tower Hamlets	91.9%	85.0%	82.2%	**86.4%**
Newham	90.6%	84.9%	74.6%	**83.4%**
Waltham Forest	89.7%	83.0%	69.6%	**80.7%**
Barking & Dagenham	89.2%	81.1%	78.6%	**82.9%**
Redbridge	85.6%	80.4%	67.6%	**77.9%**
City & Hackney	70.7%	70.3%	76.4%	**72.5%**
NEL	**87.2%**	**81.9%**	**74.5%**	**81.2%**

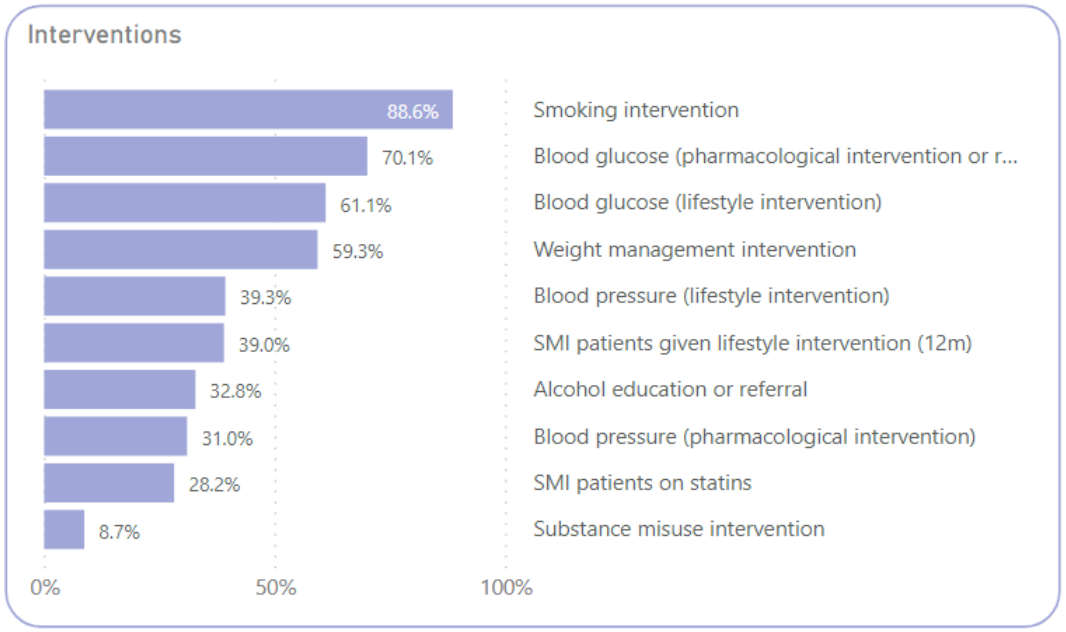
Source: Clinical Effectiveness Group (CEG)

Against the national target, 52% of residents living with SMIs have received their annual physical checks

In NEL the rate of physical checks for residents with SMIs are below target.

- As of 1st January 2023, NEL is currently 18.1% below target for physical checks in patients with severe mental illness
- There is work to be done to ensure that patients are not only aware but are encouraged to attend their physical health checks
- Risk factors such as language barriers, digital inequalities and deprivation must be taken into account to ensure that the target is consistently met.





Access: how we are measured and our plans

The 2023/24 operational planning guidance sets out a series of targets relating to general practice;

- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- 50 million more appointments in general practice by the end of March 2024
- Recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024

We are working closely with partners across general practice and primary care to address the challenges we face in general practice. Our plans include:

- utilising the capacity of the broader primary care team including new roles (eg ARRS)
- improving our communication with residents so that those needing to access support are clear on where to go when they need help
- developing a systemic approach to understanding and improving complex telephony issues
- engaging in place and PCN-based conversations about population needs to understand how existing and future capacity in general practice should meet local needs
- supporting practices to identify patients at risk of access inequality through a data quality accreditation scheme, and identifying actions to address any barriers to access
- improving data by utilising tools such as Edenbridge APEX to ensure we have the most accurate appointment and clinical information from practice clinical systems

Access: NEL performance

- The volume and rate of appointments in GP practices increased in 2022 compared with 2019
  - The number of GP appointments across NEL in 2022 increased by 17% compared with 2019
  - The average rate of appointments per 1000 patients across NEL in 2022 increased by 7% compared with 2019

- Patients are attending GP practices at higher rates than prior to the pandemic across all seven NEL boroughs
- National GP Appointment Data (GPAD) has been made available to the general public. Across London Region, three NEL GP practices were highlighted as amongst the best performing practices for providing same day appointments.

Average weekly appointment rate per 1000 registered patients for Q2 (July to September) comparison

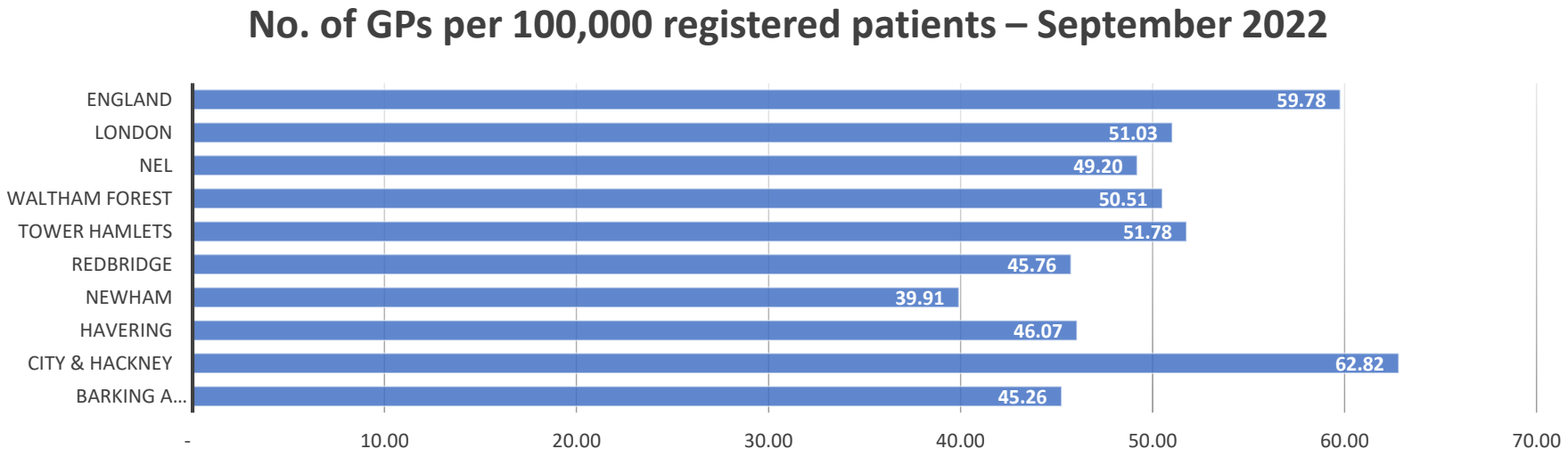
BOROUGH/PLACE	2019	2022	CHANGE (%)
BARKING AND DAGENHAM	77.8	87.6	13%
CITY AND HACKNEY	92.8	98.4	6%
HAVERING	75.2	81.3	8%
NEWHAM	74.7	79.9	7%
REDBRIDGE	79.1	87.1	10%
TOWER HAMLETS	96.1	97.5	1%
WALTHAM FOREST	75.1	80.3	7%
NEL	81.6	87.4	7%

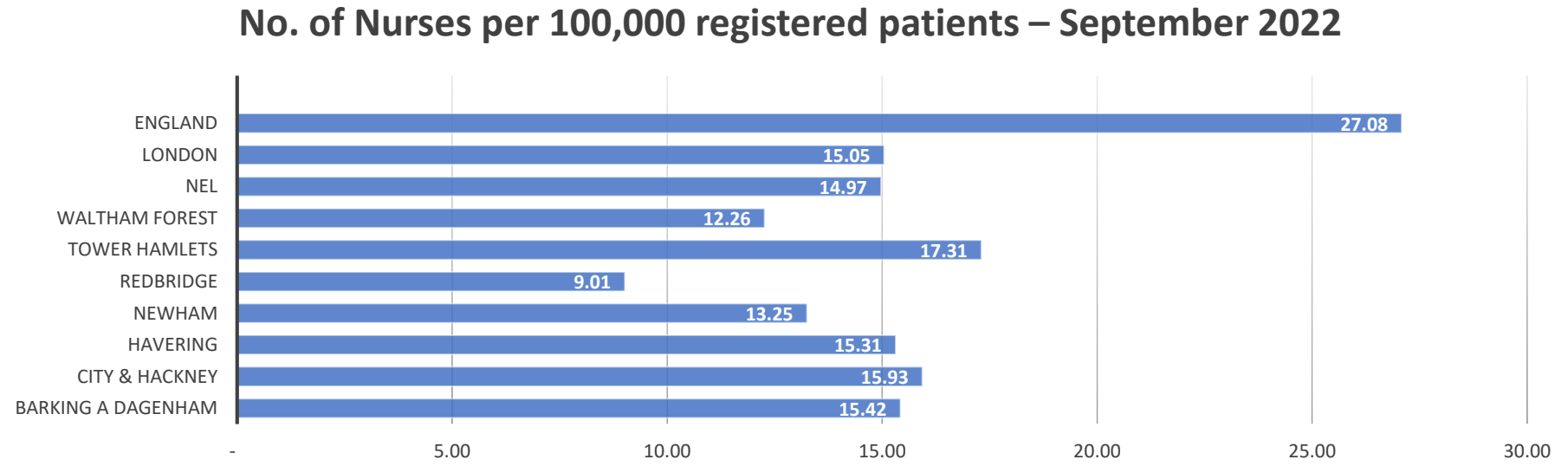
Total appointment count for Q2 (July to September) comparison

BOROUGH/PLACE	2019	2022	CHANGE (%)
BARKING AND DAGENHAM	225,296	277,707	23%
CITY AND HACKNEY	372,409	436,665	17%
HAVERING	257,926	307,072	19%
NEWHAM	405,318	472,897	17%
REDBRIDGE	343,112	401,532	17%
TOWER HAMLETS	411,070	481,770	17%
WALTHAM FOREST	304,081	341,179	12%
NEL	2,319,212	2,718,822	17%

- There has been an increase in the proportion of remote appointments provided by general practice across all seven NEL boroughs - in 2022, a third of all appointments were provided remotely

Borough ratios for GPs and Practice Nurses





A majority of NEL boroughs are below the England and London ratio for GPs, the exception being C&H.

No borough achieves the England average for practice nurses although a majority of boroughs do well against London figures with the exception of WF, Redbridge and Newham.

NEL aspires to increase staff ratios to the following levels:

- For GPs to achieve a ratio of 44 GPs per 100K by 2025
- For GPNs to achieve a ratio of 15 GPNs per 100K by 2025
- ARRS to increase utilisation year by year to 80% by 2025

Factors that impact on recruitment and retention

Pay and conditions	GP practice staff are not recruited under national pay contracts. The only exception is salaried doctors.
	ARRS roles are funded at A4C rates but the contract of employment does not reflect the same terms and conditions
	Long term sickness, paternity and adoption reimbursement only applies to GP roles
Job design:	Staff are attracted to roles that provide a good work life and provide variation and opportunity. Increasingly healthcare staff are opting for roles that offer flexibility and access to portfolio opportunities. This applies across all roles and age groups.
	To increase portfolio options we need to expand fellowship options across all roles and all age groups. This can reduce workforce capacity in the shortterm
Workload & wellbeing	Relentlessly increasing workloads lead to burnout.
	The GP contract funding allocations is based on the ***Carr Hill formula*** which does not recognise factors driving London health inequalities and workload. Almost all NEL practices have a weighted practice population lower than the raw list size. This is what determines practice income
Success & recognition	GP staff report pressures on the time they can spend with a patient. This impacts on the quality of care they can offer and successful outcome.
	Across NEL there is a variation in the funding available via LIS schemes which allows staff to spend more time with a patient. Often extending appointment times from 15 to up to 30 minutes.
Career and Personal Development	GP providers are not able to sustain people and educational functions that are the norm in larger health and social care organisations. Staff have to access this support via other organisations, Training Hubs, Federations and the ICB
	Backfill for training and supervision is not properly resourced.

ICB and training hub interventions

Improvements in workforce size and scope

- Expand the GP fellowship scheme with an aim to ensure that fellowships are offered in all PCNs.
- Through strengthened nursing leadership, training and supervision across boroughs and within PCNs we shall offer new nursing opportunities and roles that are more attractive to newly qualified staff and which help retain existing staff
- Develop recruitment pipelines, training and improved job opportunities
- Work across our partnerships to expand our SPIN / Fellowship offer beyond GP roles to ARRS staff and nursing staff. During 2022/23 we plan to have up to 10 SPIN clinical pharmacists
- Offer mentoring and guidance to newly qualified staff and existing staff to support them in finding roles with NEL suited to their career needs. During 2022/23 we intend to achieve 90% conversion of trainees within the system footprint
- Ensure that PCN and GP employers have access to workforce planning tools and information by offering a planning tool in 2022/23

Reducing attrition and improving retention by up to 2% per annum

- Expansion of SPIN offers to existing staff within and across the NEL system
- Work across the system to support interventions that reduce workload and enhance working
- Enhancement of locally led retentions schemes offered via our Training hubs
- Well-being training and resources offered to all practices
- Up-skilling and personal development offers aligned to local needs and career opportunities
- Mentorship and supervision offered to all practices
- Strengthened professional leadership and supervision
- Development of a training and supervision mapping tool to support future infrastructure investment and planning
- Expansion of the flexible pools offers

Hyperlocal programme

- NEL reviewed the variation of staffing rates per 100K across PCNs and practices. It found that variation across borough and also within boroughs.
- As a consequent we have implemented a hyperlocal work-stream that shall work with PCNs identified from heat maps to develop bespoke interventions and sustainable recruitment pipelines.
- NEL has agreed an investment package of £400K+ with the hyperlocal practices and PCNs aimed at facilitating intensive improvements in their recruitment and retention offers

NHS North East London ICB Board

25 January 2023

Title of report	Board Assurance Framework
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery, Chief Participation and Place Officer
Contact for further information	Annemarie.keliris@nhs.net
Executive summary	The paper outlines progress to date and presents the updated Board Assurance Framework (BAF) which captures the highest risks to meeting the integrated care system (ICS) aims, our purpose and four priorities. The BAF has been refined and updated following the feedback received at the board meeting on 30 November. As this is the initial year of the ICB and ICS, where we are testing and developing our system, we are anticipating that the risk management process and BAF will be further refined over the coming months. The current key risks on the BAF relate to: • Collaborative working across partners • Wider determinants of health/environment • Quality and safety of care • Delivery against control total and operating plan • Workforce • Population growth
Action required	To consider and note the updated Board Assurance Framework.
Previous reporting	ICB executive management team
Next steps/ onward reporting	• Audit and Risk Committee for assurance. • ICB and ICS executive management team to review the corporate risk register in February. • Board to receive updated BAF in March 2023
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. It relates to all ICS aims: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development

Impact on local people, health inequalities and sustainability	The paper sets out key risks within the ICB and system in order to achieve our aims for the health and wellbeing of 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.

1.0 Background

1.1 As both a statutory NHS organisation and the integrated care system (ICS) convener, the Integrated Care Board's risk register includes those risks affecting delivery of the wider ICS aims, purpose and objectives. The purpose of the Board Assurance Framework (BAF) is to set out the key risks to the Integrated Care Board (ICB) in achieving its objectives and priorities and to identify the controls and actions in place to manage those risks.

1.2 The ICB has a responsibility to maintain sound risk management processes and ensure that internal control systems are appropriate and effective and where necessary to take remedial action. It is a key part of good governance. The risk review uses the standard NHS methodology that considers the likelihood of the risk alongside the severity of its impact if it materialises. The risk score takes account of the mitigating action proposed. This then gives a risk score and categorisation of:

1-3 Low Risk Low Priority	**4-6 Medium Risk Moderate Priority**	**8-12 High Risk High Priority**	**15-25 Very High Risk Very High Priority**

1.3 The BAF is constructed around the aims of the ICS:

- 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. The BAF will be updated monthly to reflect the progress being made, as well as to identify any new risks.

2.0 Risk appetite

2.1 Following the last board meeting, risk appetite levels have been identified for each risk in line with the grading on page 10 of the attached Board Assurance Framework.

3.0 Process for escalation

3.1 Risks managed through the Committees of the ICB that are rated 15 or above should be considered for escalation to the Board. The escalated risk will continue to be maintained in the Committee's and relevant Chief Officer portfolio register. In addition, risks raised through the Board and the Integrated Care Partnership will be considered for inclusion.

4.0 Progress to date

4.1 The Board reviewed the initial draft Board Assurance Framework at its meeting on 30 November. The comments from this meeting focused on ensuring that the Framework reflects system risks and have been used to review and refine the chief officer portfolio risk registers and to update the Board Assurance Framework which is attached.

4.2 The Audit and Risk Committee continues to receive updates on the development of the risk management process and an internal audit review on the process is

taking place in January, the outcome of which is expected in February. The recommendations from this review will be considered and implemented.

4.3 During January, the executive management team reviewed the risks on the new corporate risk register which have been used to further develop the attached BAF.

5.0 Risks for escalation

5.1 The current risks, along with updated scores, escalated to the Board Assurance Framework are as follows, with the detail included in the appendix:

- There is a risk that ICS partners do not work together and with local people, communities and stakeholders in collaborative and strengths-based ways and so cannot deliver on our ICS purpose, aims and priorities and will have limited impact on improving the health and wellbeing of local people and reducing health inequalities.
- There is a risk that health and wellbeing outcomes for local people will be directly and adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include but not be restricted to, those of: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational achievements, rates of employment and types of occupation and social networks and connections.
- There is a risk that quality and safe care will be adversely affected, reflected in increasing inequalities, poorer outcomes and service failures, when we as a system do not seek to understand and prioritise the experience of local people and to act compassionately and collaboratively with them in response.
- There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents across North East London, thereby increasing health inequalities, poorer outcomes and service failures.
- There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London. In addition, a failure to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a requirement to go into recovery and potential reductions in services to local people.
- There is a risk that the failure to work together to produce and implement a coherent, whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support the wellbeing of our diverse workforce and to deliver the range of services needed by local people with adverse impacts for their health and wellbeing.
- There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.

6.0 Next steps

6.1 The Head of Governance will continue to review the corporate risk register and meet with risk champions to review risks and current mitigations. The ICB and ICS executive team will continue to discuss the organisation and system wide risks to ensure further development and refinement of the BAF.

Board Assurance Framework January 2023 – Dashboard

NB: some risks haves been updated to reflect the discussion at the last Board meeting, recognising there is further development needed, therefore while indicated as 'New' some are updated to cover broader issues and this is clear within the more detailed sheets, for example 3 is now wider than air quality following feedback.

ICS Aim	Order in BAF	Risk Description	Risk Owner	Responsible Committee	Risk Score	
					Dec/ Jan	Target
To improve outcomes in population health and healthcare	**2**	There is a risk that ICS partners do not work together and with local people, communities and stakeholders in collaborative and strengths-based ways and so cannot deliver on our ICS purpose, aims and priorities and will have limited impact on improving the health and wellbeing of local people and reducing health inequalities.	Johanna Moss	ICP Committee	**16** **NEW RISK TO BAF**	**8**
	3	There is a risk that health and wellbeing outcomes for local people will be directly and adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include but not be restricted to, those of: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, rates of employment and types of occupation and social networks and connections.	Paul Gilluley	Population Health and Integration Committee	**16** **NEW RISK TO BAF**	**6**
To tackle inequalities in outcomes, experience and access	**5**	There is a risk that quality and safe care will be adversely affected, reflected in increasing inequalities, poorer outcomes and service failures, when we as a system do not seek to understand and prioritise the experience of local people and to act compassionately and collaboratively with them in response	Diane Jones	Quality, Safety and Improvement Committee	**20** **NEW RISK TO BAF**	**8**
	7	There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents across North East London, thereby increasing health inequalities, poorer outcomes and service failures.	Diane Jones	Quality, Safety and Improvement Committee	**20** **NEW RISK TO BAF**	**8**
To enhance productivity and value for money	**1**	There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London. In addition, a failure to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a requirement to go into recovery and potential reductions in services to local people.	Henry Black	Finance, Performance and Investment Committee	**20** ⟷	**10**

ICS Aim	Order in BAF	Risk Description	Risk Owner	Responsible Committee	Risk Score	
					Dec/ Jan	Target
	6	There is a risk that the failure to work together to produce and implement a coherent, whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support the wellbeing of our diverse workforce and to deliver the range of services needed by local people with adverse impacts for their health and wellbeing.	Francesca Okosi	Workforce and Remuneration Committee	**12** **NEW RISK TO BAF**	**6**
To support broader social and economic development	**4**	There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.	Charlotte Pomery	Population Health and Integration Committee	**16** ⟷	**8**

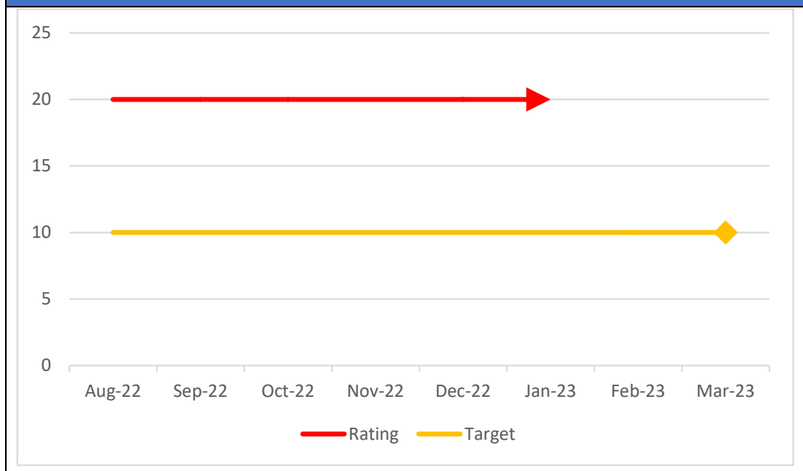
Board Assurance Framework – January 2023

ICS Aim	To enhance productivity and value for money				Risk applies to ICB	Risk applies to ICS	Risk reference	CFPO01
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Henry Black
	✓	✓	✓	✓			Responsible committee	Finance, Performance and Investment Committee

Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2
	✓	✓	✓	✓	✓	✓	✓		

Risk description	**There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London. In addition, a failure to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a requirement to go into recovery and potential reductions in services to local people.**

Score history and targets

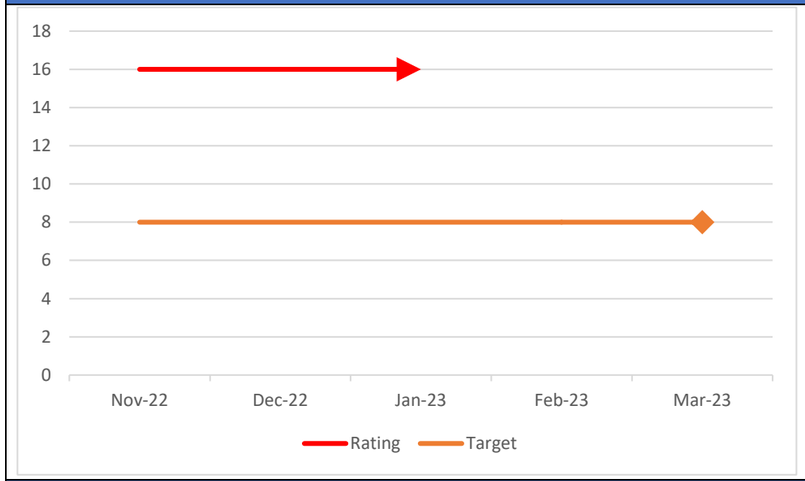


Initial rating (LxS)	Initial date	Rationale
20 (4x5)	August 2022	The system has a control total (CT) agreed with NHSE that is required to be delivered. There is considerable risk at present to achievement of the CT due to lack of long-term transformation and delivery of cost improvement programmes (CIPs), elective recovery backlog, winter pressures and workforce shortages. The risk goes beyond a financial risk and impacts on all areas of the system.
Target rating (LxS)	**Target date**	**Rationale**
10	March 2023	Mitigations in place should aid the reduction in the risk score and allow the system to deliver its statutory financial duty. However, the prerequisite to this is the reduction in spend across the system.
Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
20 (4x5)	January 2023	The system has a control total (CT) agreed with NHSE that is required to be delivered. There is considerable risk at present to achievement of the CT for this financial year and subsequent years due to lack of long-term transformation and delivery of cost improvement programmes (CIPs), elective recovery backlog, winter pressures and workforce shortages. The risk goes beyond a financial risk and impacts on all areas of the system.

Controls and assurances
Monthly system level reporting and ongoing review of specific financial risks and opportunities. Reports presented to the Executive Committee monthly and the Finance, Performance and Investment Committee bi-monthly.
Financial performance reported and reviewed by regional/national teams
Agreed Internal Audit and Counter Fraud Programmes with RSM which are reported to the bi-monthly Audit and Risk Committee
Annual External Audit with KPMG which is reported to the Audit and Risk Committee
Barking Havering and Redbridge University Hospitals Trust (BHRUT) have enhanced support from NHS England relating to system oversight framework (SOF) 4 position. Assurances are reported at meetings with regional and national teams.
Internal ICB processes to deliver greater transparency on future spend; including business case process where assurance is provided by the Business Case Assurance Group.

Mitigations/ actions to address the risk	Target date
ICS Chief Finance Officers (CFO) meetings with all system partners have been established with outcomes agreed.	Completed
Providers have been given additional funding for elective care (Elective Recovery Fund – ERF)	31.03.23
System-wide discussions are taking place to discuss the drivers of the deficit, via the financial recovery summit and system finance groups	31.03.23
System wide formal recovery programme to be stood up with key groups to take forward different areas of recovery; including workforce productivity, corporate services and temporary staffing.	31.03.23
System partners have internal efficiency programmes in place to deliver savings for this financial year	31.03.23
Finance team continues to identify ICB savings to be enacted for this financial year to be able to deliver the breakeven position that is statutorily required	31.03.23
Within the ICB - development of CIP and recovery plans for continuing health care (CHC) and prescribing.	31.03.23

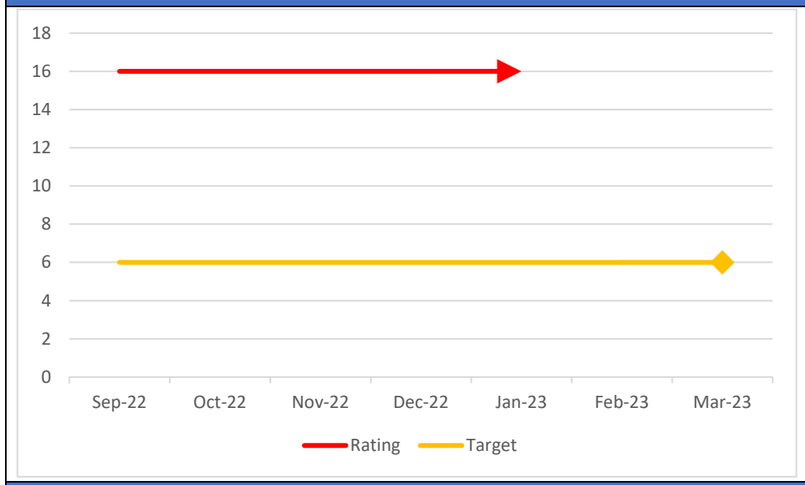
ICS Aim	To improve outcomes in population health and healthcare				Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO (no. tbc)
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Johanna Moss
	✓	✓	✓	✓			Responsible committee	ICP Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2
	✓	✓	✓	✓	✓	✓	✓		
Risk description	**There is a risk that ICS partners do not work together and with local people, communities and stakeholders in collaborative and strengths-based ways and so cannot deliver on our ICS purpose, aims and priorities and will have limited impact on improving the health and wellbeing of local people and reducing health inequalities.**							

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	Nov 2022	At the point of this risk being identified the extent of engagement required to co-produce the strategy whereby it was jointly owned by all partners was challenging. The reputational and operational impact of not developing a co-produced strategy would be severe as it's one of the key purposes of the ICP to provide the strategic framework for the local health system.
	Target rating (LxS)	**Target date**	**Rationale**
	8	March 2023	Significant work has been planned to ensure there is full engagement with a wide variety of stakeholders and partners reducing the likelihood.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	Same as initial rating as this is a newly added risk	15/11/22	

Controls and assurances
Review of current data and information including JSNAs from all 7 PBP and NEL population profile
ICP strategy development - key focus on securing PBP and provider collaborative input including engaging executives from provider collaborative e.g. Trust Chairs and Snr executives
ICP strategy discussed at CAG to ensure clinical engagement and input
ICP strategy task and finish group established to ensure system wide engagement and involvement
The ICB Executive Management Team, ICP Committee, to receive regular updates

Mitigations/ actions to address the risk	Target date
Task and finish group established with broad range of involvement from ICP system to oversee development and drafting of the strategy	Jan 2023
ICP strategy to be socialised at staff meeting, and shared with senior leadership for cascading to partners	March 2023
ICP strategy discussed at borough level with 8 x Health & Well Being Boards and 7 Place Based Partnerships	April 2023
PPE engagement on the ICP strategy through working with Healthwatch and CVS in NEL	May 2023
Series of workshops that include wide range of partners from across the system - over 200 attendees for BCYP and over 100 participants for all the others	Dec 2022

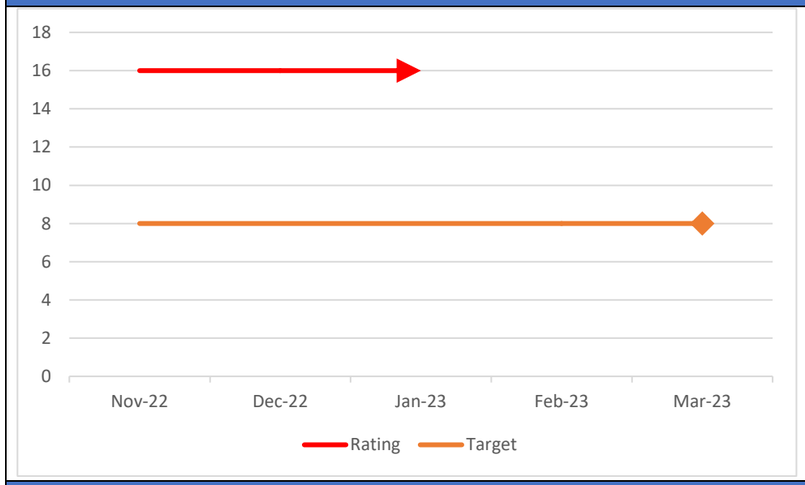
ICS Aim	To improve outcomes in population health and healthcare							Risk applies to ICB	Risk applies to ICS	Risk reference	CMO (no. tbc)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Paul Gilluley
	✓		✓		✓		✓			Responsible committee	Population Health and Integration Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2
	✓	✓	✓	✓	✓	✓	✓				
Risk description	**There is a risk that health and wellbeing outcomes for local people will be directly and adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include but not be restricted to, those of: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, rates of employment and types of occupation and social networks and connections.**										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	September 2022	NEL currently has the highest rates of air pollution in the UK and the impact of air pollution on ill health is known and individuals suffer harm because of it. The additional pressure put on the NHS system due to ill health arising from air pollution has a severe operational and reputational risk.
	Target rating (LxS)	**Target date**	**Rationale**
	6	March 2024	An ambitious target to contribute towards the reduction in air pollution locally as a system hence reducing the likelihood and thereby reducing the harm it causes to individuals and the impact on NHS as a whole.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	Same as initial rating as this is a newly added risk	September 2022	

Controls and assurances
ICS Net Zero SROs meet regularly as a system group
Reports presented to the Population health management and health inequalities steering group
Reports presented to the Population Health and Integration Committee

Mitigations/ actions to address the risk	Target date
Work with ICB partners to promote and support active staff travel approaches across NEL including walking, cycling and use of public transport	Ongoing commitment to promote active travel
Introduce low emission car rental scheme	Complete - December 2022
Scoping requirements and need for an air quality strategy for NEL including clinical lead and PMO support to be in place to champion air quality and drive strategic relationships with wider system to focus on addressing air quality and to highlight health cost of poor air quality on people's health outcomes	May 2023
Travel and transport working group established with involvement from across ICB system	July 2023
Introduced salary sacrifice staff bike scheme across ICB	Complete - Jan 2023

ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO11
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Charlotte Pomery
	✓	✓	✓	✓			Responsible committee	Population Health and Integration Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2
	✓	✓	✓	✓	✓	✓	✓		
Risk description	**There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.**							

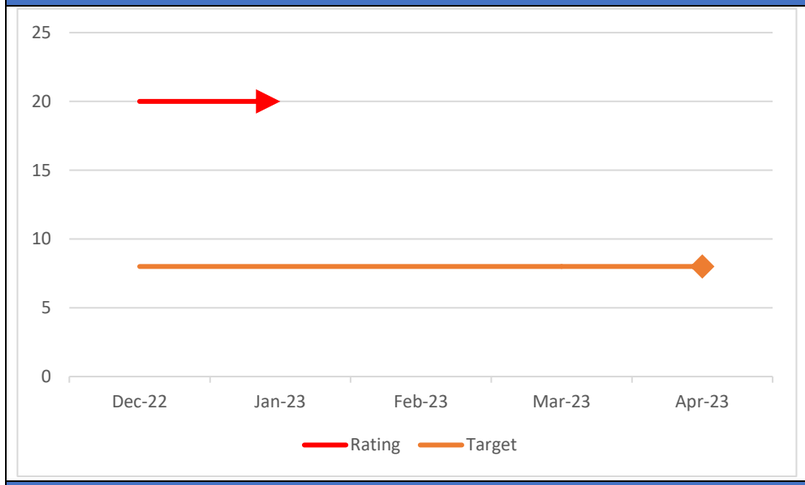
Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	November 2022	Given the rapid population growth expected in north east London, there is a need to develop the infrastructure required to support people's health and wellbeing against a challenging economic backdrop.
	Target rating (LxS)	**Target date**	**Rationale**
	8	March 2023	Establishment of the ICS and ICB and all associated structures and governance are still in progress which keeps this as a risk
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	16 (4x4)	December 2022	As above, mitigating actions are still in progress and not yet in place/resolved

Controls and assurances

The implementation of ICB and ICS governance structures which include various committees and sub-committees which are held on monthly or bi-monthly basis with ICS partners. Minutes of these meetings can be provided for assurance

Mitigations/ actions to address the risk	Target date
Establishment of Local Infrastructure Forums	March 2023
Development of long-term Strategic Infrastructure Approach	March 2023
Dedicated work with local authorities through Place Partnerships and cross-Place Partnership working	March 2023
Progress of development projects such St George's, Havering and the Ilford Exchange in Redbridge.	March 2023

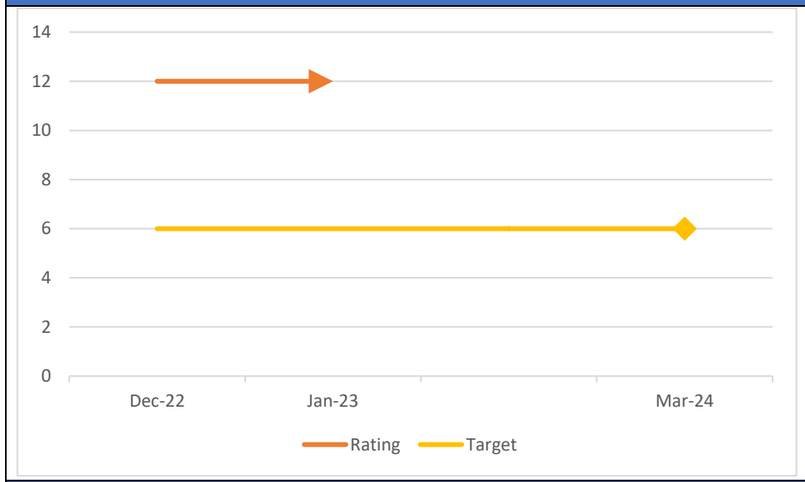
ICS Aim	To tackle inequalities in outcomes, experience and access			Risk applies to ICB	Risk applies to ICS	Risk reference	CNO (no. tbc)
					✓		
ICS priority	Children and young people	Mental health		Employment and workforce	Long term conditions	Risk owner	Diane Jones
	✓	✓		✓	✓	Responsible committee	Quality, Safety and Improvement Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2
	✓	✓	✓	✓	✓	✓	✓		
Risk description	There is a risk that quality and safe care will be adversely affected, reflected in increasing inequalities, poorer outcomes and service failures, when we as a system do not seek to understand and prioritise the experience of local people and to act compassionately and collaboratively with them in response						

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	20 (5x4)	December 2022	Considerable system risks that may have an impact on quality and safe care
	Target rating (LxS)	**Target date**	**Rationale**
	8	April 2023	Significant programmes of work are planned or underway that will enable greater oversight across the System
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	20 (5x4)	December 2022	Programme Boards/groups and improved ways of working/ collaboration across the system are starting to be explicit re this - should result in good practice and greater collaboration becoming embedded

Controls and assurances
Incident Management calls across the ICS have been implemented.
System Oversight Command Group stood up across NELHCP.
The NEL System Quality Group meets quarterly to discuss System Quality issues
Mental Health/ Learning Disability and Autism (MHLDA) Programme Board in place to review System MHLDA issues
Urgent and Emergency Care Programme Board in place to review system UEC risks and programmes of work to support improvement
Partnership of East London Co-operatives (PELC) Assurance and Improvement Groups meets to assure PELC actions against Care Quality Commission actions and support improvement conversations across NHR geography
Quality, Safety and Improvement Committee (QSI) in place to review System/ Place quality issues

Mitigations/ actions to address the risk	Target date
Escalation discussions taking place across London Chief Nurse network and Chief Medical Officer network - also replicated across NELHCP	Feb 23
Consideration to be given to areas of clinical activity that could be stood down if needed.	Feb 23
Review the possibility of requesting additional clinical support across the system and possible redirection of clinical support	Feb 23
After Action Review and Clinical Harm Review processes to be determined	Feb 23
Impact of industrial action discussion at QSI Committee	08/02/23
System programmes to support UEC improvements discussion at QSI Committee	08/02/23

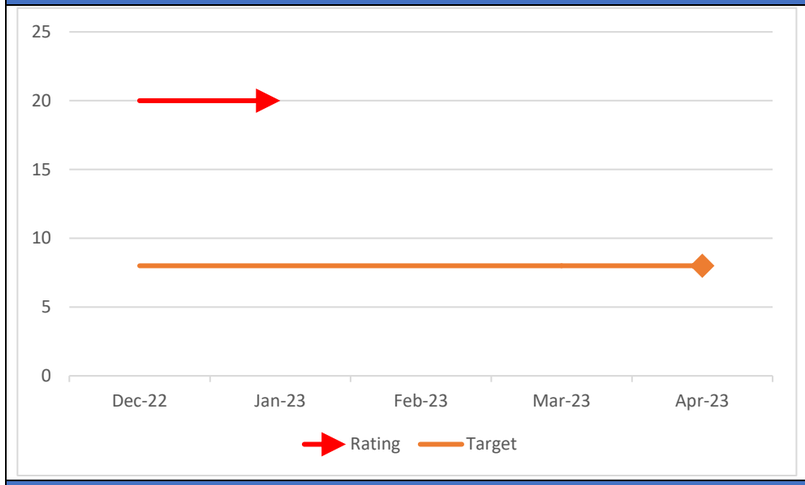
ICS Aim	To enhance productivity and value for money							Risk applies to ICB	Risk applies to ICS	Risk reference	CPCO02
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Francesca Okosi
	✓		✓		✓		✓			Responsible committee	Workforce and Remuneration Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2
	✓	✓	✓	✓	✓	✓	✓				
Risk description	There is a risk that the failure to work together to produce and implement a coherent, whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support the wellbeing of our diverse workforce and to deliver the range of services needed by local people with adverse impacts for their health and wellbeing.										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**12 (3x4)**	December 2022	Given our current service requirements and workforce pressures, that cuts across organisations, if we do not plan and deploy effectively we will not be in a position to deliver the range of services required. And, may impact on the health and well-being of our workforce.
	Target rating (LxS)	**Target date**	**Rationale**
	6 (2x3)	March 2024	To ensure a consistent and health and well-being offer is maintained for all staff across north east London (NEL). Plans developed and in place to allow flexible deployment and minimum employment of staff across NEL. Development of new roles that can be trained and deployed quickly to NEL utilising apprentice pathways, new roles and retention initiatives. Also to ensure pathways and processes are in place to support and encourage local people into health and care employment.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	Same as initial rating as this is a newly added risk		See above

Controls and assurances
Workforce workshop held 1 November 2022.
High level strategy for initial sign off at ICB EMT March 2023
Presentation of the outline strategy to Workforce and Remuneration committee in February 2023
Final strategy for approval and sign off at Executive Leadership Team end of March 2023

Mitigations/ actions to address the risk	Target date
Initial engagement with Local Authorities, providers voluntary sector since October 2022	Completed – engagement continues as required
High level outline drafted for overall ICS strategy.	January 2023
Further engagement with all system partners on further shaping and developing the strategy	February 2023
Draft strategy document to be completed by February and ready for review	February 2023
Outline workforce strategy to be signed off by March 2023.	March 2023
Confirmation of funding to continue the Keeping Well officer for staff into 23/24	March 2023
Set up a task and finish group to develop and agree a minimal employment offer and flexible deployment of staff	September 2023
Ensure full utilisation of the levy and infrastructure to support learning in the workplace. Building cohorts of up skilled staff incrementally	January 2024
Through existing health and care recruitment hubs a commitment to offer 900 posts to local residents - incrementally up to 2024 funded by the GLA	January 2023 and ongoing

ICS Aim	To tackle inequalities in outcomes, experience and access							Risk applies to ICB	Risk applies to ICS	Risk reference	CNO (no. tbc)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Diane Jones
	✓		✓		✓		✓			Responsible committee	Quality, Safety and Improvement Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2
	✓	✓	✓	✓	✓	✓	✓				
Risk description	**There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents across North East London, thereby increasing health inequalities, poorer outcomes and service failures.**										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**20 (5x4)**	December 2022	Considerable resource and workforce capacity risks that may have an impact on quality and safe care
	Target rating (LxS)	**Target date**	**Rationale**
	8	April 2023	Significant programmes of work are planned or underway that will enable greater oversight across the System
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	20 (5x4)	December 2022	See above – new

Controls and assurances
Incident Management calls across the ICS have been implemented.
System Oversight Command Group stood up across NELHCP.
The NEL System People Board are in place
Recruitment across Clinical Leadership roles to support improvement programmes to address risk ie Director of Allied Health Professionals role
International recruitment campaigns in place across all NEL Providers i.e. NELFT programme in Africa
Nursing and Midwifery Workforce Expansion Board – regional group to deliver against the Government promise to increase nursing and midwifery numbers

Mitigations/ actions to address the risk	Target date
Escalation discussions taking place across London Chief Nurse network and Chief Medical Officer network - also replicated across NELHCP	Feb 23
Consideration to be given to areas of clinical activity that could be stood down if needed.	Feb 23
Review the possibility of requesting additional clinical support across the system and possible redirection of clinical support	Feb 23
After Action Review and Clinical Harm Review processes to be determined	Feb 23
Impact of industrial action discussion at QSI Committee	08/02/23
System programmes to support UEC improvements discussion at QSI Committee	08/02/23

NB – controls and assurances to be fully updated for next BAF given this is newly added as above reflects quality risk 5 on BAF but do also relate to this item.

SUPPORTING INFORMATION

Appetite description	Appetite level
Averse: Avoidance of risk is a key objective	1
Cautious: We have limited tolerance of risk with a focus on safe delivery	2
Open: We are willing to take reasonable risks, balanced against reward potential	3
Bold: We will take justified risks.	4

Committees of the Integrated Care Board:

- Population Health and Integration Committee
- Quality, Safety and Improvement Committee
- Audit and Risk Committee
- Finance, Performance and Investment Committee
- Workforce and Remuneration Committee
- Executive Committee

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

Risk grading matrix

Risk Category	
Severe	
High	
Medium	
Low	

											Likelihood					
											Rating	**1**	**2**	**3**	**4**	**5**
											Description	**Rare**	**Unlikely**	**Possible**	**Likely**	**Certain**
											Probability	**<10%**	**10% - 24%**	**25% to 45%**	**50% - 74%**	**>75%**
Severity	**Rating**	Description	A Objectives/ projects	B Harm/injury to patients, staff visitors & others	C Actual/potential complaints & claims	D Service disruption	E Staffing & competence	F Financial	G Inspection/ Audit	H Adverse media						
	1	**Insignificant**	Insignificant cost increase/time slippage. Barely noticeable reduction in scope or quality	Incident was prevented or incident occurred and there was no harm	Locally resolved complaint	Loss/ interruption more than 1 hour	Short term low staffing leading to reduction in quality (less than 1 day)	Small loss <£1000	Minor recommendations	Rumours	1	**1**	**2**	**3**	**4**	**5**
	2	**Minor**	Less than 5% cost or time increase. Minor reduction in quality or scope	Individual(s) required first aid. Staff needed <3 days off work or normal duties	Justified complaint peripheral to clinical care	Loss of one whole working day	On-going low staffing levels reducing service quality	Loss of 0.1% budget.	Recommendations given. Non-compliance with standards	Local media	2	**2**	**4**	**6**	**8**	**10**
	3	**Moderate**	5-10% cost or time increase. Moderate reduction in scope or quality	Individual(s) require moderate increase in care. Staff needed >3 days off work or normal duties	Below excess claim. Justified complaint involving inappropriate care	Loss of more than one working day	Late delivery of key objectives/service due to lack of staff. On-going unsafe staff levels. Small error owing to insufficient training	Loss of more than 0.25% of budget.	Reduced rating. Challenging recommendations. Non-compliance with standards	Local media lead story	3	**3**	**6**	**9**	**12**	**15**
	4	**Major**	10-25% cost or time increase. Failure to meet secondary objectives	Individual(s) appear to have suffered permanent harm. Staff have sustained a "major injury" as defined by the HSE	Claim above excess level. Multiple justified complaints	Loss of more than one working week	Uncertain delivery of services due to lack of staff. Large error owing to insufficient training	Loss of more than 0.5% of budget.	Enforcement action. Low rating. Critical report. Major non-compliance with core standards	Local media short term	4	**4**	**8**	**12**	**16**	**20**
	5	**Severe**	>25% cost or time increase. Failure to meet primary objective	Individual(s) died as a result of the incident	Multiple claims or single major claims	Permanent loss of premises or facility	No delivery of service. Critical error owing to insufficient training	Loss of more than 1% of budget.	Prosecution. Zero rating. Severely critical report.	National media more than 3 days. MP concern	5	**5**	**10**	**15**	**20**	**25**

NHS North East London ICB board

25 January 2023

Title of report	Month 8 2022-23 Finance overview and Month 7 Performance overview
Author	Julia Summers
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 November was £2,713m. • The ICS has reported an unfavourable system variance to plan at month 8 of £55.4m, primarily due to inflationary pressures and slower than planned delivery of system savings and cost improvements. • Within the ICS year to date position, the ICB has reported an underspend of £12.5m which includes the clawback of £24.7m of Elective Recovery Funds from system partners. • The system and ICB has reported a forecast outturn to plan. However, given the level of risk this is likely to change at month 9 for some organisations in the ICS. • The ICB Chief Finance and Performance Officer (CFPO) has constituted a finance recovery working group across the whole of the ICS. This group will review and drive forward the in-year financial position, efficiency and savings targets and oversee the development of a five year system financial plan. • The report updates on proposed changes to the Scheme of Reservation and Delegation (SORD). • The performance update presents an analysis of key system operational performance and indicators against national and locally agreed targets relating to acute, mental health, community and primary care services. The data is based on Month 7 (October 2022). • The NEL performance dashboard is included in Appendix 1.
Action required	• Note the content of the report and the key risks to the expected year-end breakeven position.

	• Approve the proposed update to the scheme of reservation and delegation. • Note the content of the performance update and note the key risks of delivery.
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 2022/23 operating plan. The report provides an update of finance and performance against the plan.
Impact on local people, health inequalities and sustainability	Update of financial sustainability and performance of the system. Specific performance indicators address performance against the needs of those with protected characteristics (as defined by the Equalities Acts), such as disability and this is included in the report.
Impact on finance, performance and quality	Delivery of the financial plan, meeting the financial control total and delivery of performance metrics and constitutional standards are mandated requirements.
Risks	Financial risks are outlined in the paper. Key risks have been identified as inflation, efficiencies and ICB run rate pressures within CHC and prescribing. Further system risk has been identified in relation to workforce and pay pressures with partners and system wide investment programmes. Key performance risks are highlighted in the paper and have been identified in planned care, outpatient transformation, diagnostics, cancer, urgent and emergency care (UEC) and mental health.

NORTH EAST LONDON ICB BOARD – MONTH 8 2022-23 FINANCE OVERVIEW AND MONTH 7 PERFORMANCE OVERVIEW

1. Purpose of the Report

The month 8 finance update provides the ICB Board with an update on the year-to-date and forecast financial position of both ICB and NEL system. It provides a summary of the month 8 financial position and describes the drivers of spend and risks inherent in the delivery of the required break even position.

The month 7 performance update provides NEL ICB with the latest published performance position and the risks associated with delivery. The performance dashboard is attached in Appendix 1.

The ICB Board is asked to note the information in the finance and performance overview and is recommended to approve the changes to the Scheme of Delegation and Reservation (SORD).

This paper links to the legal requirement to deliver a balanced financial position

2. Month 8 Finance Overview and update to the SORD

The month 8 year-to-date position across the NEL system is a overspend variance to plan of £55.4m. This is made up of a provider overspend variance of £67.8m with an ICB underspend position of £12.5m.

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

	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
BHRUT	(2.0)	(26.3)	(24.3)	0.0	0.0	0.0
Barts Health	0.0	(34.9)	(34.9)	0.0	0.0	0.0
East London NHSFT	(0.9)	(2.7)	(1.7)	0.0	0.0	0.0
Homerton	(0.3)	(6.5)	(6.3)	0.0	0.0	0.0
NELFT	0.0	(0.6)	(0.6)	0.0	0.0	0.0
Total NEL Providers	**(3.2)**	**(71.0)**	**(67.8)**	**0.0**	**0.0**	**0.0**
NEL ICB	0.0	12.5	12.5	0.0	(0.0)	(0.0)
NEL System Total	**(3.2)**	**(58.5)**	**(55.4)**	**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.
- **Provider Payroll costs** – providers have reported pressures in relation to staff pay, including agency staffing. Average total monthly pay across all providers is £237m and is on an upward trajectory compared to the same period last year. There was an

increase in payroll costs between months 7 and 8 with the largest increases seen at ELFT and the Homerton.

- **Agency spend** – providers have flagged payroll pressure, specifically in relation to spend on agency staff. The total amount forecast to be spent is £188m. However, extrapolation of current rates indicates that the year-end position without mitigation would be in the range of £193m to £212m. Whilst this is a reduction on the month 7 forecast range and would cause the ICS to breach the agency cap imposed as part of the operating plan.
- **Efficiency and cost improvement plans** - the total system efficiency and cost improvement plan at month 8 is £117m. Providers and the ICB have assessed performance against this target and are reporting slippage against the plan of £39m. These plans included an overall reduction in payroll costs have 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 £11m.
- **Elective Recovery** - the system has been given specific funds to help deliver elective recovery though the reduction of waiting lists. At month 8 targets have not been met and therefore £24.7m of funds have been held within the ICB year-to-date position and a correlating pressure reported within provider accounts. NHSE have confirmed that they will not claw back any elective recovery funds and that any elective recovery risk should be managed at system level.

2.1.1 - ICB year to date position

A level of efficiencies was built into the ICB budgets in the planning cycle. However, there is still an unidentified efficiency target which has led to a year-to-date pressure of £21.1m at month 8. The ICB has a continued run rate pressure in CHC of £4.9m relating to high cost package and observation costs and a run rate pressure in prescribing of £3.1m (4% of budget). The prescribing pressure has been driven by activity and price increases, with price concession increases a significant risk to the year-end forecast. Part of these pressures are offset by other ICB budgets, with the remainder offset by the clawback of elective recovery funds from system providers and non-recurrent balance sheet mitigations. This is shown in the table below.

Month 8	YTD Variance £m
ICB Run Rate Pressures	
Operating Plan Budgetary Pressure	(21.1)
Community Health	1.1
Continuing Care	(4.9)
Primary Care - Delegated	0.0
Primary Care - Other	(3.1)
Programme Corporate	1.7
Other Areas	4.6
Total Pressure	**(21.8)**
Mitigation	
ERF clawback	24.7
Identified non-recurrent mitigations	9.3
Run rate review / investment slippage	0.3
Total Mitigation	**34.3**
Month 8 Position	**12.5**

2.1.2 - 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 actions that can be taken to address this.

2.1.3 - ICB Forecast position

The ICB has a number of underlying run rate pressures, however at month 8 it is continuing to report a forecast breakeven. This is highlighted in the table below.

Month 8	FOT Variance £m
ICB Run Rate Pressures	
Operating Plan Budgetary Pressure	(38.0)
Community Health	(1.3)
Continuing Care	(8.4)
Primary Care - Delegated	(2.5)
Primary Care - Other	(3.3)
Programme Corporate	(3.4)
Other Areas	3.7
Total Pressure	**(53.1)**
Mitigation	
ERF clawback	0.0
Identified non-recurrent mitigations	34.2
Run rate review / investment slippage	6.8
To be identified	12.1
Total Mitigation	**53.1**
Month 8 Position	**0.0**

To enable this position to be achieved the ICB will need to deliver a number of mitigating actions in the latter part of the financial year. Delivery of these mitigating actions and a reduction in run rate will need to occur in areas that the ICB has influence and the ability to impact spend.

Delivery of mitigating actions will be challenging in the latter part of the year, and will need to consider non recurrent and recurrent measures. This will include; continuing to review and deliver efficiency opportunities, working with system wide partners to drive a sustainable financial position across the ICS, reviewing the delivery, profiling and impact of all investments, and analysing non-recurrent opportunities including a review of all balance sheet items and provisions. To date approximately £34.2m of non-recurrent mitigations have been identified.

Delivery of the forecast outturn clearly represents a risk to the ICB, further updates will be given to future committee meetings.

2.1.4 – Financial 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 8 across the system is £132.9m. Mitigations of £104.6m have been identified, this includes £25m which will need to be delivered through the finance recovery summit actions. Therefore, the residual risk reported to NHSE is £28.3m. These risks relate to revenue risks only and they 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
BHRUT	Efficiency - Delivery	High	(26.0)	(16.0)
Barts	Excess inflation risk for items included within plans	High	(27.0)	(27.0)
Barts	Contracting/SLA issues (including ESRF contractual issues)	Medium	(0.1)	(0.1)
Barts	Contracting/SLA issues (including ESRF contractual issues)	High	(0.7)	(0.7)
ELFT	Efficiency - Delivery	High	(7.8)	(5.5)
ELFT		High	(1.0)	(1.0)
Homerton	Temporary Staffing	High	(5.0)	(2.2)
Homerton	Contracting/SLA issues (including ESRF contractual issues)	High	(0.1)	(0.1)
Homerton	Excess inflation risk for items outside of plans	High	(0.8)	(0.8)
NEL ICB	Other Risk - run rate risk	High	(12.0)	0.0
NEL ICB	CHC	High	(8.4)	0.0
NEL ICB	Prescibing	High	(8.0)	0.0
System Wide	ESRF risk (excluding ESRF contractual issues)	High	(36.0)	0.0
System Wide	Strike action	High	0.0	0.0
System Wide	Mitigation	Medium	0.0	25.0
Total Risk			**(132.9)**	**(28.3)**

- **Inflation, Workforce pressures, Elective recovery** and **delays in Efficiencies** and cost improvement will continue to manifest as risks throughout the remainder of the financial year, as described in the table above.
- **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.

Given the year to date position, and the level of risk within the forecast outturn, the ICS partner organisations are working together to try to mitigate the financial pressures. **Potential mitigations** to offset the financial risks identified include:

- The ICB CPFO has constituted a finance recovery group working across the whole of the ICS. The group will review and drive forward the in-year financial position, efficiency and savings targets and oversee the development of a five year system financial plan.
- Given the level of risk contained within the system financial position and the continued year-to-date pressure being reported it is likely that at least two organisations in the system will report a year-end forecast deficit at month 9. This will lead to an overall system reported deficit. As a result of this NHSE's deficit protocol will be enacted. The ICB CPFO is leading a process across the system to ensure that the relevant conditions and criteria within the deficit protocol are delivered. Further updates to the Board, Finance Performance and Investment Committee (FPIC) and other sub groups will be given throughout the financial year.

3 - Scheme of Reservation and Delegation (SORD)

As part of the ongoing review of financial assurance it is requested that the Board approve the following change to the Scheme of Reservation and Delegation.

Single Tender Waivers to be approved by only the Chief Finance and Performance Officer

At present these can be approved by Place Director, the Director of Finance, joint approval from three of the Chief Officers as well as FPIC and the Board. Amending this to only the Chief Finance and Performance Officer will allow greater transparency over those areas which are waiving the procurement rules and the reasons for this. They will continue to be reviewed by the Procurement Group and a report sent to the Audit and Risk Committee.

4 – Month 7 Performance Overview

The Month 7 performance update provides NEL ICB with the latest published performance position which has been presented to the Finance, Performance and Investment Committee (FPIC) on the 6th of January, 2023 and approved with some required updates.

The ICB Board is asked to note the information in the report and it is also worth mentioning that the Performance reported on here relates to month 7 (October 2022) due to the timing of published validated data by NHS Digital. This report not only provides a summary of the performance position but also describes the risks and mitigations to the reported position.

Key headlines are;

4.1.1 - Planned Care

- The overall NEL referral to treatment waiting list fell in October 2022 due to a decrease in the number of patients waiting at BHRUT and Barts Health for treatment in an outpatient setting.
- The number of patients waiting for a year or more for their planned care continues to reduce.
- The number of patients being seen in NEL remains lower than planned, the nationally set objective is for activity to be 104% of 2019 levels (reflecting recovery to pre-pandemic levels of activity). Consultant led outpatient activity was at 90% of pre-pandemic levels in Oct-22.

4.1.2 - Outpatient Transformation

- GPs are able to access specialist advice and guidance / referral assessment and triage. 28% of all first outpatient appointments were managed via this route in Oct-22.
- Patients were also able to initiate their own follow up appointments (PIFU) with the aim to reduce appointments that are nnot needed / booking of follow-up appointments by default for 1.2% of all outpatient appointments in Oct-22, the highest volume at NEL level YTD.
- 20% of all outpatient appointments were delivered virtually (video/telephone) in Oct-22 across NEL

4.1.3 - Diagnostics

- There were 51,325 patients waiting for a diagnostic test in NEL this month and 9,151 patients had been waiting more than six weeks.
- NEL continues to see improvements in performance but still has the highest volume of patients waiting an imaging investigation in London in Oct-22.

4.1.4 - Cancer

- In Oct-22, NEL delivered five of the nine cancer waiting time constitutional standards for patients. However, treatment for patients within 62 days from urgent GP referral still requires improvement.

4.1.5 Urgent & Emergency Care

- In Nov-22, 1,216 arrivals by ambulance at NEL emergency departments (EDs) took more than 1-hour to be transferred from London Ambulance service care . 79% of all handovers took place within 60 minutes a marginal deterioration from 80% in Oct-22.
- 23% of arrivals by ambulance were handed over from London Ambulance Service care within 15 min of arrival at ED.
- 52% of arrivals by ambulance were handed over within 30 mins of arrival at ED.
- NEL has the highest volume of patients waiting over 12-hours for admission across London ICBs.
- In Nov-22, 63% of all patients were seen within 4-hours of arrival at ED.

4.1.6 - Health Services in the Community

- In Oct-22 we have delivered lower than planned GP appointments.
- Oct-22 saw an increase in community services waiting lists in children services, 1,488 have waited over 52 weeks and 160 over 104 weeks.

4.1.7 - Mental Health

- A number of measures of service performance have improved when compared with the end of 2021/22. However, the plans set for the end of 2022/23 remain at some risk, as the rate of improvement needs to increase substantially.
- Services of note are; Improving Access to Psychological Therapies (IAPT, Talking Therapies), Children and Young People's (CYP) mental health access, Perinatal mental health support to women, Dementia diagnosis, and Physical Health Checks for people with Serious Mental Illness (SMI).

4.1.8 - Month 7 Performance Risks, Challenges and mitigations:

- **Planned Care** – there is a risk with the number of patients continuing to wait for a year or longer. This has an implication for 2023/24 and challenges the delivery of required levels of inpatient and outpatient activity to manage new referral demand, sustain/reduce the overall waiting list, and reduce long waits.

  Productivity programmes are in place at all three NEL Trusts (at hospital site level) with the aim to improve inpatient activity via improved theatre productivity and utilisation. Additional theatres also due to come online across NEL in 2023/24 via the 'Targeted Investment Fund' to bolster inpatient activity to support recovery, as well as support longer-term strategic objectives and anticipated growth.

- **Outpatient Transformation -** there is risk with continued growth in the number of patients awaiting outpatient appointments and treatment.

  As a mitigation to this there is ongoing work to ensure patients waiting are equipped with the information they need, including support and advice to ensure they are able

to ‘wait well’. Additionally, programmes of work will continue to look at specialties experiencing significant growth.

- **Diagnostics** - Risks highlighted at Homerton in relation to sickness related absences and available staffing, resulting in clinic cancellations.

  As a system, NEL ICB is working to reduce long waiters, with focus on ensuring all patients waiting over 26 waits are reviewed and/ or have a date, managed via the local recovery programme.

- **Cancer -** Deterioration in the number of patients waiting more than 62 days for treatment from urgent referral week on week, with risk of the requirement for weekly assurance meetings with NHSE region.

  NEL is exploring the use of AI technologies (a project that will be funded by our Cancer Alliance) to mitigate this challenge moving forward. Additionally, the system has taken measures to recruit new staff and explore digital solutions.

- **UEC –** Staffing shortages present risk to both four-hour performance and ability to take handovers from Ambulance Crews across NEL**.**

  As a system, site-by-site review of actual practice and best practice across NEL for Ambulance Handovers is ongoing.

  2023/24 Operating Plan focuses on improvements in ambulances handovers, 4-Hr Performance recovery for UEC and a 2-yr recovery plan is expected from NHSE.

- **Health Services in the Community** - there is a continued risk with an increase in demand for GP appointments and long waiting times for children’s services.

- **Mental Health -** There remains risk in relation to delivery of required levels of service improvement, and achieving year end performance will be challenging.

  As a system, there are recovery plans in place for IAPT (Talking Therapies), Children and Young People’s (CYP), and Perinatal Access. These recovery plans are supported by clinically led NEL wide groups.

NEL ICB has systems and processes in place to ensure all performance measures across different frameworks are closely monitored, prioritised and escalated where appropriate.

Appendix 1 Performance Dashboard Month 7

Planned Care Recovery & Transformation – Oct 2022

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published October-2022			
		Achievement	Trajectory	Actual	Change from prev. Month
Planned Care	Total Waiting List (volume)	✓	197,853	196,715	▼
	Waiting List >104 Weeks (volume)	×	0	37	▼
	Waiting List >78 Weeks (volume)	×	849	951	▼
	Waiting List >52 Weeks (volume)	×	6,767	8,949	▼
	Clock Stop Activity (% 19/20 BAU)	×	84.5%	79.7%	▼
	Inpatient Elective Activity (% 19/20 BAU)	×	101.4%	88.8%	▼
	Consultant Led Outpatient Attendances (% 19/20 BAU)	×	98.8%	90.2%	▼

KEY

Latest monthly where appropriate are shown as RAG :
✓ ON × OFF track vs. trajectory.

Change from prev. month indicates movement from the previous month based on validated published data
▼/▲ deterioration ▼/▲ improvement

Key Headlines

- The overall NEL RTT waiting list fell in Oct-22 to 196,715 pathways (-3,750 pathways from the Sep-22 position), due to a decrease in the number of patients waiting at BHRUT and Barts Health for treatment in an outpatient setting.
- The number of patients waiting 2 or more years (>104 weeks) for their planned care continues to reduce, with 37 patients awaiting treatment at Barts Health in Oct-22. There are 0 patients waiting 2 or more years at BHRUT or HUH. The >104ww position at Barts Health has since improved further and achievement is anticipated.
- The number of patients waiting 18 months or more (>78 weeks) in NEL also fell in Oct-22, due to fewer patients waiting at Barts Health for inpatient treatment.
- The number of patients waiting 1 year or more (>52 weeks) also fell in Oct-22, due to improvements at BHRUT and HUH.
- In line with RTT rules a patient's RTT clock is stopped at the point of first definitive treatment, or other clinical decision not to treat, removing the patient from the live RTT waiting list. In Oct-22, the volume of clock-stops fell to 80% against 2019/20 baselines.
- The number of patients being seen in NEL remains lower than planned, the nationally set objective is for activity to be 104% of 2019 levels (reflecting recovery to pre-pandemic levels of activity). Consultant led outpatient activity was at 90% of pre pandemic levels in Oct-22, BHRUT reporting the lowest levels. Inpatient activity was 89% of pre pandemic levels in Oct-22, Barts Health reporting the lowest levels.

Workstream Issues and Risks

- The number of patients continuing to wait 2 years or more (>104 weeks) at Barts Health.
- Risk of patients continuing to wait 18 months or more (>78 weeks) at Barts Health and BHRUT post Mar-23.
- Risk to delivery of the ask to reduce the volume of patients waiting 1 year or more (>52 weeks) and implications for 2023/24.
- Challenge in delivery of required levels of inpatient and outpatient activity to manage new referral demand, sustain/reduce the overall waiting list, and reduce long waits.

Mitigating Actions and Next Steps

- Regional weekly monitoring of the volume of patients waiting 18-months or more, and / or will be waiting post Mar-23 by specialty, including escalation, requirement for recovery actions and assurance where required.
- Bi-weekly assurance meetings held with NHSE region and Barts Health to support treatment of all patients waiting 2 years and those at risk of waiting 18 months or more at year end, including requirement for, and review of, specialty level actions.
- Review and agreement of approach, and monitoring of, national validation asks and guidance at individual Trust and NEL level, based on a risk stratified / prioritised approach to ensure waiting lists include only patients genuinely requiring / wanting treatment.
- Productivity programmes are in place at all three NEL Trusts (at hospital site level) with the aim to improve inpatient activity via improved theatre productivity and utilisation. Additional theatres also due to come online across NEL in 2023/24 via the 'Targeted Investment Fund' to bolster inpatient activity to support recovery, as well as support longer-term strategic objectives and anticipated growth.

Governance

- The NEL Planned Care Recovery and Transformation Programme continues to lead the overarching transformation and programmes of work to support planned care performance and delivery against national priorities
- Bi-weekly assurance meetings held with NHSE region and Barts Health
- Trust productivity programmes overseen by the NEL Surgical Optimisation Group
- NEL risks, delivery and recovery escalated via the Planned Care Board

Outpatient Transformation – Oct 2022

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published October-2022			
		Achievement	Trajectory	Actual	Change from prev. Month
Outpatient Transformation	Specialist Advice (volume)	✓	15,987	18,451	▲
	Specialist Advice (% OPFA)	✓	National Req. 16%	28.34%	▲
	Moved or Discharged to PIFU (volume)	×	5,439	2,710	▲
	Moved or Discharged to PIFU (% OPA)	×	National Req. 5% in Mar-23	1.20%	▲
	Outpatient Virtual Activity (volume)	×	59,293	45,654	▼
	Outpatient Virtual Activity (%)	×	National Req. 25%	20.26%	▼

KEY

Latest monthly where appropriate are shown as RAG :
✓ ON × OFF track vs. trajectory.

Change from prev. month indicates movement from the previous month based on validated published data
▼/▲ deterioration ▼/▲ improvement

Key Headlines

- GPs are able to access specialist advice and guidance / referral assessment and triage, with the intention to reduce outpatient appointments. The volume of GP advice and guidance requests received and responded to by Barts, BHRUT and HUH is increasing YTD. 28% of all first outpatient appointments were managed via this route in Oct-22.
- Patients were also able to initiate their own follow up appointments (PIFU) with the aim to reduce un-needed appointments / booking of follow-up appointments by default for 1.2% of all outpatient appointments in Oct-22, the highest volume at NEL level YTD.
- 20% of all outpatient appointments were delivered virtually (video/telephone) in Oct-22 across NEL (with variance across the three Trusts - Barts Health 15%; BHRUT 23% and HUH 34%).

Workstream Issues and Risks

- Continued growth in the number of patients awaiting outpatient appointments and treatment.
- Relatively low volumes of patients able to initiate their own follow-up appointments (PIFU) and significant risk to year end achievement (5% ask).

Mitigating Actions and Next Steps

- Ongoing development and work to ensure patients waiting are equipped with the information they need, support and advice to ensure they are able to 'wait well' via various mechanisms and tools (e.g. 'My Planned Care' platform, 'Waiting Well' and 'Waiting Well in NEL website').
- Ongoing roll-out of 'Advice and Refer' pilots across NEL (whereby all GP referrals receive advice and guidance prior to referral with the aim to reduce referrals, join up working, and 2-way support education).
- Workshop planned for early Feb to further develop and agree programmes of work / areas of focus to support reduction in follow-up appointments of limited value (incl. to increase roll out and use of patient initiated follow-up).
- Deep dives completed in specialties experiencing significant growth (i.e. Dermatology). Dermatology task and finish group established to agree the top priorities for NEL, support the implementation of pilot pathways, and facilitate shared learning, with an aim to tackle the challenges being faced.
- Targeted reduction to improve patient DNA rates (e.g. the 'outpatient reminder service' in BHRUT).

Governance

- The NEL Planned Care Recovery and Transformation Programme continues to lead the overarching transformation and programmes of work to support planned care performance and delivery against national priorities
- Progress against priorities, risks and delivery are raised via the Outpatient and Out-of-Hospital Steering Group, escalating to the Planned Care Board

Diagnostics – Oct 2022

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published October-2022			
		Achievement	Trajectory	Actual	Change from prev. Month
Diagnostics	Total Waiting List (volume)	N/A	N/A	51,328	▲
	Waiting List >6 Weeks (volume)	N/A	N/A	9,153	▲
	Performance (%)	N/A	N/A	18%	▼

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

Key Headlines

- In Oct-22, there were 51,325 patients waiting for a diagnostics test in NEL, and 9,151 patients had been waiting more than six weeks.
- NEL continues to see improvements in performance but still has the highest volume of patients waiting an imaging investigation in London in Oct-22. The number of patients waiting over 6 weeks is the highest at Barts Health, predominantly driven by waits for MRI and CT.
- BHRUT returned to national reporting for the month of Oct-22, following the pause to reporting in July-22. Both CT and NOUS (non-obstetric ultrasound), are now within the 95% tolerance for patients waiting under 6-weeks. Waits for MRI are also on track for full recovery by the end of Mar-23. The majority of patients who remain waiting 6 weeks or more have appointments booked.
- The majority of patients waiting at HUH are waiting less than 6 weeks (delivering above the 95% tolerance), the challenged diagnostic tests are MRI and Echo.

Workstream Issues and Risks

- Risks highlighted at HUH pertaining to sickness related absences and resulting clinic cancellations, staffing resource across (radiographers, administrative staff and sonographers, increase in NOUS (non-obstetric ultrasound demand) and loss of MRI capacity due to scanner breakdown
- Reporting cross sectional backlog at BHRUT and risk now at highest level in addition to increasing reporting activity to create a downward trajectory.

Mitigating Actions and Next Steps

- Reduced MRI very long waiters, with focus on ensuring all patients waiting over 26 waits are reviewed and/ or have a date, managed via the local recovery programme.
- NEL to agree scope of review of contracts with third parties in the new year.
- NEL to agree operational sustainability approach for system Demand and Capacity (D&C) and next steps.
- NEL Hospital teams in the process of developing operational plans for 23/24 Financial Year

Governance

- NEL diagnostics performance risks, delivery and recovery are discussed at the Monthly Diagnostics Programme Board.
- Imaging , Endoscopy and Echo Networks established with regular meetings held weekly.
- NEL Imaging Planning and recovery meeting continues weekly with attendance from all three NEL Trusts.

Cancer – Oct 2022

SRO:	Femi Odewale	RAG	AMBER

	Metric	Latest Published October-2022			
		Achievement	Trajectory	Actual	Change from prev. Month
Cancer	31 Day Treated (volume)	✗	593	487	▲
	Waiting List >62 Days (volume)	✗	724	736	▲
	Waiting List >104 Days (volume)	N/A	N/A	178	▲
	Faster Diagnosis Standard (%)	✗	75.59%	72.97%	▼

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

Key Headlines

- In Oct-22, NEL delivered five of the nine cancer waiting time constitutional standards for patients. However, treatment for patients within 62 days from urgent GP referral still requires improvement.
- The reason why some patients are waiting more than 62-days is attributed to challenges associated with diagnostic histopathology, imaging delays, increased referrals and turnaround times for diagnostic reports.
- The faster diagnosis and treatment standard (communication with patients of confirmed cancer or ruling out of cancer) was below trajectory in Oct-22 for the first time following many months of previous compliance.

Workstream Issues and Risks

- Deterioration in the number of patients waiting more than 62 days for treatment from urgent referral week on week, with risk of the requirement for weekly assurance meetings with NHSE region.
- In addition, operational pressures Gaps identified in MDT administration's PTL management knowledge, Clinical PTL Management, Histopathology and Inter-Trust Pathway delays

Mitigating Actions and Next Steps

- NEL have introduced tele dermatology at BHRUT and Bart's and utilising an insourcing service at Homerton to support the system with the influx in demand in 2WW and Faster Diagnosis (FDS) activity.
- NEL is also exploring the use of AI technologies (a project that will be funded by our Cancer Alliance) to mitigate this challenge moving forward.
- In order to tackle the 62 Day Performance & Backlog Reduction across NEL, the system has taken measures such as making a £1.2m investment to recruit new staff (histology), utilise locum and insourcing companies and exploring digital solutions.
- The Cancer Alliance has also funded additional specialist improvement assistance to support Bart's and BHRUT with their backlog reduction plan and 62 day improvement.

Governance

- NEL Cancer Alliance is funded by, and accountable to the National Cancer Programme within NHS England for the delivery of two key objectives: *NHS Long Term Plan and Delivery of the Constitutional Standards*
- NEL Cancer Performance risk and recovery planning is managed at an ICB level via the NEL Cancer Alliance. There is a weekly NEL Cancer Achieving Planning Guidance Goals meeting attended by the three Acute Provider Trust. This Forum enables discussion of local delivery, key projects and sharing of best practice across NEL.
- NEL Cancer Position is also monitored by NHSE London region through monthly Delivery Assurance

Urgent and Emergency Care – Oct 2022

SRO:	Clive Walsh	RAG	RED

	Metric	Latest Published November-2022			
		Achievement	Trajectory	Actual	Change from prev. Month
UEC	Ambulance Handovers ≥ 60 Min (volume)	✗	National Req. ZERO	1,216	▲
	12-hour Trolley waits (volume)	✗	National Req. ZERO	1,629	▼
	Total A&E Attendances (volume)	N/A	N/A	82,858	▲
	A&E 4-Hour Performance All Type (%)	✗	National Req. 95%	63.33%	▼
	A&E 4-Hour Performance Type 1 (%)	✗	National Req. 95%	51.07%	▼
	Total A&E Admissions (volume)	N/A	N/A	11,012	▼

KEY

Latest monthly where appropriate are shown as RAG :
✓ ON × OFF track vs. trajectory.

Change from prev. month indicates movement from the previous month based on validated published data
▼/▲ deterioration ▼/▲ improvement

Key Headlines

- In Nov-22, 1,216 arrivals by ambulance at NEL emergency departments (EDs) took more than 1-hour to be transferred from London Ambulance service care (up 78 on previous month, driven by BHRUT). 79% of all handovers took place within 60 min (Barts 82%, BHRUT 63%, HUH 100%), a marginal deterioration from 80% in Oct-22.
- 23% of arrivals by ambulance were handed over from London Ambulance service care within 15 min of arrival at ED (Barts 19%, BHRUT 6%, HUH 66%), improved from 21% in Oct-22.
- 52% of arrivals by ambulance were handed over within 30 mins of arrival at ED (Barts 53%, BHRUT 24%, HUH 96%), no significant change from Oct-22.
- NEL has the highest volume of patients waiting over 12-hours for admission (from the point at which a decision is made that the patient requires admission) across London ICBs.
- In Nov-22, 63% of all patients were seen within 4-hours of arrival at ED, BHRUT being the most challenged. 51% of Type 1 patients (often considered the most Acute patients) were seen within 4-hours.

Workstream Issues and Risks

- Staffing shortages present risk to both 4hr performance and ability to take handovers from Ambulance Crews
- High numbers of Medically Optimised patients (the point at which care and assessment can safely be continued in a non-acute setting), combined with poor discharges, impact flow and cause delays
- Primary Care capacity challenges resulting in increased numbers of patients in the UEC environment
- Limited Primary Care appointment slots available to 111 in some localities
- Use of SDEC (same day emergency care space and capacity) for medical and surgical patients reducing UEC capacity
- Industrial action impacts on flow and safety

Mitigating Actions and Next Steps

- Site-by-Site review of actual practice vs SOPs and best practice across NEL for Ambulance Handovers
- Tracking of staffing volumes and skill mix against performance to identify trends/patterns
- Inclusion of bed occupancy levels data analysis to show impact of flow constraints
- Arrival by ambulance numbers to be tracked and compared
- Primary Care management ,(including via 111) of low acuity patients, workshop to explore variances across NEL footprint
- Engagement with Place Leads to examine Community Beds and Domiciliary Care capacity vs demand for discharges needing care packages.

Governance

- NEL UEC Programme Board (chaired by CMO)
- NEL UEC Programme Executive (chaired by CEO)
- NEL IA Incident Management Meetings (chaired by CPO)

Health Services in the Community – Oct 2022

SRO:	Charlotte Pomery	RAG	AMBER

	Metric	Latest Published			
		Achievement	Trajectory	Actual	Change from prev. period
Health Services in the Community	Appointments in General Practice - Oct-22	✗	1,048,899	1,031,294	▲
	Learning disability registers and annual health checks delivered by GPs - Q2 22/23	✓	11.29%	41.93%	▲
	Personal Health Budgets - Q2 22/23	✓	3,880	4,583	▲
	2-hour Urgent Community Response (UCR) care contacts - Count of 2-hour UCR first care contacts delivered within reporting quarter - Q2 22/23	✓	1,651	4,563	▲
	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 - Q2 22/23	✓	31,607	29,519	▼
	Number of CYP (0-17 years) on community waiting lists - Q2 22/23	✗	11,245	14,996	▲
	Number of Adults (18+ years) on community waiting lists - Q2 22/23	✓	20,362	14,523	▼

KEY

Latest month/quarter where appropriate are shown as RAG :
✓ ON × OFF track vs. trajectory.

Change from prev. period indicates movement from the previous period based on validated published data
▼/▲ deterioration ▼/▲ improvement

Key Headlines

- Oct-22 we have delivered lower then planned GP appointments. However, since August we have seen an increase in the number of GP appointments being offered and expect to hit the November trajectory. Around 50% of the GP appointments were delivered either on the same day or the next day.
- Oct-22 saw an increase in community services waiting lists in children services, 1,488 have waited over 52 weeks and 160 over 104 weeks. These waits come from Community paediatric service, Looked after children, Nursing and therapy teams and speech and language.

Workstream Issues and Risks

- GP appointments – demand for face to face appointments.
- Children waiting lists – the key issues for long waits have been reported as increase in demand and referral, workforce and workforce capability and skill mix.

Mitigating Actions and Next Steps

- GP appointments performance will be monitored at the Primary Care Collaborative, nationally the data is published at ICB level, but locally we are able to track this at place to understand local variation.
- Children waiting list – performance will be tracked at the community collaborative and place based partnerships to drive improvement.

Governance

- Primary care collaborative
- Community collaborative

Mental Health – Oct 2022

SRO:	Dan Burningham	RAG	AMBER

	Metric	Latest Published			
		Oct-22	*Trajectory*	*Actual*	Change from prev. Month
Mental Health	IAPT Access (Volume)	✗	*4,079*	*4,042*	▼
	Dementia Diagnosis (Rate)	✗	*66.70%*	*59.60%*	▲
	SMI Physical Health Checks (Performance)	✗	*60.00%*	*44.52%*	N/A
	Perinatal (Rate)	✗	*7.98%*	*7.24%*	▲
	CYP Access (Volume)	✗	*23,592*	*22,041*	▼
	Early Intervention in Psychosis (EIP)	✓	*60.00%*	*67.81%*	▼
	CYP Eating Disorders Urgent Referral (Performance)	✗	*95.00%*	*91.38%*	N/A
	CYP Eating Disorders Routine Referral (Performance)	✗	*95.00%*	*86.02%*	N/A

KEY

Latest monthly where appropriate are shown as RAG :
✓ ON × OFF track vs. trajectory.

Change from prev. month indicates movement from the previous month based on validated published data
▼/▲ deterioration ▼/▲ improvement

Key Headlines

- A number of measures of service performance have improved when compared with the end of 2021/22. However, the plans set for the end of 2022/23 remain at some risk, as the rate of improvement needs to increase substantially.
- Services of note are; Improving Access to Psychological Therapies (IAPT, Talking Therapies), Children and Young People's (CYP) mental health access, Perinatal mental health support to women, Dementia diagnosis, and Physical Health Checks for people with Serious Mental Illness (SMI).
- The NEL position compared with other London systems is mixed. CYP access and SMI health checks are performing well against the London position, however Dementia diagnosis performance is challenged compared to other London regions.

Workstream Issues and Risks

- There remains risk in relation to delivery of required levels of service improvement, and achieving year end performance will be challenging.

Mitigating Actions and Next Steps

- There are recovery plans in place for IAPT (Talking Therapies), Children and Young People's (CYP), and Perinatal Access. These recovery plans are supported by clinically led NEL wide groups.
- These plans propose changes to service models to improve effectiveness and productivity, and address health and social inequalities, as well as aligning investment and workforce planning. Examples of actions being undertaken include:
  - IAPT access – a focus on recruitment and increasing referral rates, and increasing uptake of group therapy
  - CYP access – increasing primary care access, improving digital access by service users, and increase access in schools via Mental Health support teams
  - Perinatal – increasing capacity through recruitment

Governance

- Performance risk and recovery planning is managed at an ICB level via the monthly NEL Mental Health, Learning Disability and Autism Programme Board, and the fortnightly NEL Mental Health Planning and Performance Group meeting.
- This is also monitored by the NHSE London region through quarterly Delivery Assurance Monitoring, and Mental Health Programme Data Collection.

NHS North East London ICB board

25 January 2023

Title of report	Executive Committee exception report
Author	Katie McDonald, Governance Manager
Presented by	Zina Etheridge, Chief Executive Officer
Contact for further information	Katie McDonald, Governance Manager, katie.mcdonald3@nhs.net
Executive summary	On 12 January 2023 the Executive Committee of the Integrated Care Board received reports on the following items for noting: • Developing the ICS workforce strategy • Joint forward plan • ICS strategy • Financial position The paper received regarding the workforce strategy outlined the positive outputs from a workshop held in November 2023 and that codesigning the strategy will begin with stakeholder groups, including primary care, local government, voluntary and community services and wider care sector partners between January and March 2023. The joint forward plan, ICS strategy and latest financial position are being presented to the Board and discussed at its meeting on 25 January 2023.
Action required	Note
Previous reporting	None – this is an exception report from 12 January meeting.
Next steps/ onward reporting	The committee meets again on 9 February 2023 and a regular exception report will be presented to the Board.
Conflicts of interest	There are no conflicts of interest identified in relation to this report.
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The committee has an overall focus on addressing inequalities, reducing variation and improving equity for all the people of north east London while ensuring participation and co-production is central to our collective approach.
Impact on finance, performance and quality	The committee is established to provide executive oversight of the ICS system budget and financial delegations to ensure delivery of system control total and financial improvement

	trajectory. Provide executive oversight of system finance and associated risks. Ensure opportunities for bidding for transformational funding are maximised and provide oversight of bids. Approve matters in line with the scheme of reservation and delegation.
Risks	The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

NHS North East London ICB board

25 January 2023

Title of report	Audit and Risk committee exception report
Author	Anna McDonald, Senior Governance Manager
Presented by	Sue Evans, Interim Audit & Risk committee chair
Contact for further information	anna.mcdonald@nhs.net
Executive summary	The inaugural meeting of the Audit and Risk Committee took place on 21 September 2022 and the Chair provided an update to the ICB board on 28 September 2022 in regard to the due diligence report relating to the closedown of the North East London CCG on 30 June 2022. This report provides an overview of key items from the meeting held on 7 December.
Action required	The board is asked to note the report.
Previous reporting	None – this is an exception report from the 7 December 2022 meeting.
Next steps/ onward reporting	The committee meets again on 1 February 2023 and a regular exception report will be presented to the board.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The remit of the committee is to contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management, internal control processes and arrangements to manage conflicts of interest within the ICB.
Impact on finance, performance and quality	N/A
Risks	The Committee will be driven by the organisation's objectives and the associated risks and its duties will be governed by the Terms of Reference. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

1.0 Introduction

1.1 The inaugural meeting of the Audit and Risk Committee took place on 21 September 2022 and the Chair of the Committee provided an update to the ICB board at its meeting in September in regard to the due diligence report relating to the closedown of the North East London CCG on 30 June 2022.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The committee noted the work undertaken by the Emergency Preparedness, Resilience and Response lead noting that the ICB is a category one responder. The outcome of the recent self-assurance submission to NHS England was also noted. It was agreed that the ICB Resilience Group will report periodically to the Audit Committee.

2.2 Committee members were given an overview of the recently commissioned Freedom to Speak Up 'Guardian Service' and members welcomed having a more independent approach for staff.

2.3 The ICB's internal auditor – RSM updated the committee on the outcome of the recent Continuing Healthcare (CHC) and Personal Health Budgets audit. Committee members discussed the ongoing challenges. A progress report on CHC was requested for the March committee meeting.

2.4 An update on the work of the Local Counter Fraud Specialist team was presented and committee members welcomed the Fraud & Bribery and Conflicts of Interest (COI) training sessions taking place with staff.

3.0 Risks and mitigations

3.1 The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

Author: Anna McDonald, Senior Governance Manager
December 2022

NHS North East London ICB board

25 January 2023

Title of report	Workforce and Remuneration committee exception report
Author	Anna McDonald, Senior Governance Manager
Presented by	Diane Herbert, Non-executive member
Contact for further information	anna.mcdonald@nhs.net
Executive summary	This report provides an overview of key items from the meeting held on 5 December.
Action required	The board is asked to note the report.
Previous reporting	None – this is an exception report from the 5 December 2022 meeting.
Next steps/ onward reporting	The committee meets again on 22 February 2023 and an exception report will be presented to the board going forward.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	Employment and workforce – to work together to create meaningful work opportunities and employment for people in north east London now and in the future.
Impact on local people, health inequalities and sustainability	The Committee will receive assurance on the ICB's Employment Flagship Priority, ensuring that we utilise the ICB's ability to provide meaningful and positive employment opportunities for local residents.
Impact on finance, performance and quality	The Committee and all of its members are bound by the ICB's Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB.
Risks	The Committee will be driven by the organisation's objectives and the associated risks and its duties will be governed by the Terms of Reference. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1 The purpose of this report is to provide an overview of the agenda items discussed at the December meeting and any resulting actions.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The committee received a quarterly report presented by the ICB's Freedom to Speak Up Guardian executive lead and an overview of the recently commissioned Freedom

to Speak Up ‘Guardian Service’ was given. Committee members welcomed having a more independent approach for staff.

2.3 The committee were advised that Phase 1 of the internal re-structure has been completed and that Phase 2 would commence on 23 January 2023.

2.4 An update on the continued development of the ICS People and Workforce Strategy was received. Members welcomed the level of engagement taking place with all sectors across the system including local authorities, voluntary sector and primary care as well as our existing workforce.

2.5 A detailed discussion took place in regard to clinical care and professional leadership. Committee members were advised that having a consistent London-wide approach has been agreed. Further discussions are being arranged with other London ICB colleagues with the aim of presenting a proposal to the committee as soon as possible in the new year.

3.0 Risks and mitigations

3.1 The duties of the committee will be driven by the ICS and organisation’s objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

Author: Anna McDonald, Senior Governance Manager
December 2022

NHS North East London ICB board

25 January 2022

Title of report	Report from the Quality Safety and Improvement (QSI) committee, held on 7 December 2022 exception report
Author	Diane Jones, Chief Nursing Officer
Presented by	Imelda Redmond, Non Executive Director
Contact for further information	Diane Jones, diane.jones11@nhs.net
Executive summary	The second meeting of the Quality Safety and Improvement (QSI) committee was held on 7 December 2022 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. • At the meeting we discussed NEL position and progress across the vaccination programmes, the committee were assured that all steps were being taken to raise awareness and increase uptake among residents. • The committee received a report of safeguarding children and adults, noting areas of risk and good practice. • The committee received a report previously shared at the Learning Disability and Autism (LDA) board. The committee received reassurance that the system has oversight of challenges and mitigation to maintain the safety of in patients. • The committee received a paper outlining the care of residents in care homes and those with a home care package. The committee were assured of the work to enhance services, including vaccination and digital support. • There committee heard an update of the work undertaken across the system led by the Local Maternity and Neonatal System (LMNS). • The committee were asked to approve 4 safeguarding policies. The committee asked that the policies be reviewed by a small group to then recommend for approval to the committee at the next meeting, • There was a paper assuring the committee of the urgent and emergency care pathway programme. • The committee reviewed the CNO risk register and noted mitigations. There was a request to separate operational and strategic risks. This will be shared at the next committee meeting.
Action required	The board is asked to: • Note the areas of quality improvement and quality assurance discussed by the QSI committee

Previous reporting	The topics covered in this report has previously been considered and scrutinised by the QSI committee
Next steps/ onward reporting	The safeguarding policies will be reviewed by a small group and brought back for approval in February 2023.
Conflicts of interest	There are no known conflicts of interest
Strategic fit	This report aligns with: • 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	Each topic is an area of service delivery which aims to improve the quality of care for local people through recognising opportunities for quality improvement and or implementation of an updated new policy.
Impact on finance, performance and quality	All the topics show improved performance, although in some areas such as vaccination among health and care workers, there is still a lot more needed to improve uptake. All the topics highlight areas for further quality improvements, particularly where joint working at place is beneficial for local delivery.
Risks	Of the topics discussed by QSI the greatest risks noted are UEC pathway, resident access to unplanned care Maternity – Delivery against the Ockenden recommendations Uptake of vaccinations among health and care workers

Quality Safety and Improvement committee exception report

1.0 Purpose of the report

1.1 This report provides the Board with an overview of the items discussed at the QSI committee held on 7 December 2022 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. There were rich discussions reflecting the strategic importance of the papers presented to the work of all partners.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The Committee discussed system risks which will help to inform the forward planning of items for discussion and or approval.

2.2 The committee heard about the vaccination programme. A primary aim is to support wellbeing, preventing illness and hospital admissions. This is part of the system winter plan, and beyond as covers all age all year round.

2.3 It was assuring to know that all Care Home residents in NEL have been visited and offered Covid vaccinations, although the uptake for Covid vaccinations has declined for the general public. It is low for particular ethnic groups. Covid and flu vaccinations are also low for health and social care workers.
There is sufficient capacity by providers across NEL, the issue is one of low demand. There are borough specific communications and engagement activities to address this.

2.4 The committee were assured by the efforts being made by each place to ensure safeguarding partnerships are proactive and responding to safeguarding issues.

2.5 A number of policies, were shared that had been updated from CCG to ICB. A small group will be convened (safeguarding forum members and Human Resources where required) to review and recommend approval to the board.

2.6 Following from the recent media documentaries regarding concerns around the care and treatment of patients with a learning disability and autism, there was a formal letter from Clare Murdoch (Mental Health Director, NHS England) to all systems asking for assurances regarding the safety and quality in all mental health, rehabilitation and learning disability wards across local systems.
The paper presented was for assurance to the committee, and it briefly summarised the measures both providers trusts within NEL ICS (NELFT and ELFT) have put in place.

2.7 The committee received an update on the care home and home care improvement programme. Gaps in progress were noted and the committee were assured that this is being addressed through the system care provider forum.

2.8 The committee received reports on maternity and the urgent and emergency care programmes. Both of which are on the CNO risk register.

3.0 Risks and Mitigations

The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

3.1 There are no additional risks arising as a result of this report.

Diane Jones 30 December 2022

NHS North East London ICB board

25 January 2023

Title of report	Finance, Performance and Investment Committee exception report
Author	Matthew Knell, Senior Governance Manager
Presented by	Henry Black, Chief Finance and Performance Officer Kash Pandya, Associate non-executive member/ Chair of the finance, performance and investment committee
Contact for further information	matthew.knell@nhs.net
Executive position summary	The latest meeting of the Finance, Performance and Investment Committee (FPIC) was held on Friday 6 January 2023 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. At the meeting, amongst other business, the Committee discussed the measures being taken and the risks that need to be mitigated to meet the year end financial position requirements set by NHS England (NHSE) for the NHS North East London (NEL) Integrated Care Board (ICB) and the NEL health system. It also approved a business case for a Community Phlebotomy service that will operate across Barking, Havering and Redbridge, delivered by North East London NHS Foundation Trust (NELFT). This report provides an overview of the agenda items discussed and any resulting actions.
Action required	The Board is asked to note the report.
Previous reporting	None – this is an exception report from the 6 January 2023 meeting
Next steps/ onward reporting	The Committee meets again on Monday 27 February 2023 and a regular exception report will be presented to the Board.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	• To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	One of the Committee's responsibilities is to review and approve allocation of contingency funding which is to include transformation, productivity and to aid the reduction of health inequalities for the residents of North East London.
Impact on finance, performance and quality	The Committee is established to provide assurance and oversight to the Board on the robustness of the short- and long-term financial strategy and management for the ICB. It will

	provide assurance to the ICB on operational performance as it relates to the Operational Planning guidance for acute and non-acute metrics, both constitutional and non-constitutional standards as appropriate.
Risks	The duties of the Committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1 The latest meeting of the Finance, Performance and Investment Committee (FPIC) took place held on Friday 6 January 2023 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The committee received an update on the current finance and performance position for the ICS and the ICB, which included an overview of the Month 8 (November 2022) financial position and Month 7 (October 20220 performance position, outlining key issues across a number of areas including urgent and emergency care. The Executive Director of Finance updated members on discussions and work that had taken place since the previous meeting in October 2022, including briefing members on the work of the FPICs sub groups, such as the Financial Recovery Group.

2.3. The Committee discussed the risks and opportunities present across the local health system, including the proposed actions being taken by NHS North East London (NEL) and NHS partners to meet NHS England's requirements as set out in the year end out-turn protocol. Members welcomed the commitment of all the partners in doing so but remained concerned about the scale of the challenges faced. Members agreed to undertake a series of 'deep dive' exercises to explore some of these risks, including on prescribing planned for March 2023.

2.4 The Committee approved the business case for North East London NHS Foundation Trust's (NELFT) Community Phlebotomy service, which will be delivered across Barking, Havering and Redbridge and takes the pilot service which had been stood up during the Covid-19 pandemic on to a recurrent footing going forward. The estimated cost is £1,618,282 from November 2022 to October 2023. The Committee asked that the contracting process result in a relatively short agreement, less than 3 years, which will allow colleagues to ensure that this service is not a stop gap, but an integrated service across acute, community and primary care that provides a long-term solution to accommodate potential changes in laboratory access and a net zero ready transport fleet.

2.5 The Committee endorsed the NHS NEL Financial Strategy which sets out the approach to financial policy for the 2023/24 planning round and which has been refined through discussion and debate across all Places in NEL. This approach includes the top-slicing of NHS NEL's 2023/24 budget to create an investment pool focused on dampening future demand for acute care, which for 2023/24 will be 1% of the total NHS NEL budget received from NHSE and controlled by the FPIC on behalf

of the system. The Strategy further recognises that Places are becoming the engine for driving change within NEL and that giving them as much budgetary flexibility as possible will help them to consider the wider determinants of our population's health, while finding ways to support and strengthen primary care services. The investment pool will operate through inviting a mixed allocation approach, considering both thematic and place led bids for the funding. The FPIC members welcomed the commitment to place based working, flagging how important transparency across the system would be in ensuring its success through the upcoming financial year.

2.6 The Committee was briefed on the initial information made available regarding allocations for the next two financial years from NHSE, recognising that a first draft plan would need to be submitted back to NHSE before the next FPIC meeting. Feedback would be invited from FPIC members by email between meetings on this item and it was flagged that the allocations represented something of a shift back to pre pandemic working, with the return of elements of the 'payment by results' (PbR) system. Technical guidance would also become available in the coming weeks and the February 2023 meeting of the FPIC would receive a more thorough briefing.

2.7 The Committee received an initial update on the transfer of delegated responsibility for commissioning of Pharmacy, Optometry and Dental services from NHS England, which NHS NEL would be hosting for London ICBs. This initial briefing will be followed up by more detailed information on the results of due diligence undertaken on this transfer at the next FPIC meeting.

3.0 Risks and mitigations

3.1 The duties of the Committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

3.2 The are no additional risks arising as a result of this report.

Author: Matthew Knell, Senior Governance Manager
Date: 13/01/2023

NHS North East London ICB board

25 January 2023

Title of report	Population health and integration committee exception report
Author	Katie McDonald, Governance Manager
Presented by	Marie Gabriel, ICS Chair/ Chair of the Population Health and Integration Committee
Contact for further information	Katie.mcdonald3@nhs.net
Executive summary	The last meeting of the population health and integration committee was held on 13 December 2022 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. This report provides an overview of the agenda items discussed and any resulting actions.
Action required	The Board is asked to note the report.
Previous reporting	None – this is an exception report from the 13 December meeting.
Next steps/ onward reporting	The committee meets again on 22 February 2023 and a regular exception report will be presented to the Board.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access
Impact on local people, health inequalities and sustainability	The remit of the committee is to identify opportunities to support and improve effective population health management and integration of health and care services at place and within collaboratives for the residents of north east London.
Impact on finance, performance and quality	N/A
Risks	The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

1.0 Introduction/ Context/ Background/ Purpose of the report

1.1 The Population Health and Integration Committee was held on 13 December 2022 and this exception report outlines the key messages and actions taken by its

members in accordance with its terms of reference. There were rich discussions reflecting the strategic importance of the papers presented to the work of all partners.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The Population Health and Integration Committee (the Committee) held its second meeting on 13 December 2022.

2.2 The first item on the agenda was regarding population health management (PHM) which is a way of working to help frontline teams and system planners understand current health and care needs and predict what residents will need in the future. When practised correctly and implemented fully, PHM should support ICS aims, is a fundamental building block for a successful ICS and can help us deliver value-based healthcare. The Committee welcomed the information in the report, commenting on the need to be bolder by committing to not tolerate healthcare racism which is a driver of some health inequalities and also highlighted the need for all system partners to look at all work through a health inequalities lens going forward. The Committee discussed how this strategy and tackling health inequalities need to come together as one is a subset of the other.

2.3 The Committee received a paper which described our ways of working as a system in north east London. The report explained how our seven place partnerships and our five provider collaboratives are crucial building blocks of North East London's integrated care system. Together with NHS North East London they play distinct but crucially interdependent roles in driving the improvement of health, wellbeing, and equity for all local people. Our governance system supports us to be accountable to our population by reflecting our core purpose and aims across all our decision making and resources – financial, human, estate, community – will be used strategically and collaboratively to support our purpose. As a growing population with financial constraints, we need to change what and how we provide services; investing in prevention, making our system efficient and productive, optimising our estate through co-location and integration, building community diagnosis and early identification, upskilling all partners to contribute fully and focusing specialisms where they can have most impact. The committee requested that, going forward, a standing item is presented to expand on how the partnership interfaces using place-based and collaborative examples as there is a need to ensure that all are moving toward a shared ambition and not unintentionally preventing the ambition of one another.

2.4 A paper was presented that provided an update on some of the content being developed for the integrated care strategy document specifically in relation to the four system priorities for north east London; babies, children and young people, long term conditions, mental health and local employment and workforce; as well as the place priorities and emerging collaborative work on priorities. The content had been shaped by a series of system workshops involving people working in all parts of our system and local residents as well as discussions with local health and wellbeing boards and place-based partnerships. The success measures that were proposed are a set of high-level outcomes relating to the four ICS priorities and health inequalities which all parts of the system would be expected to contribute to. The Committee welcomed the report and suggested that further reference is made to local people's homes and acknowledged that the strategy will be adapted and amended over time.

2.5 The final report presented to the Committee was a discussion item to set out our ambition for working with residents and communities in north east London. At the heart of our system is our shared commitment to co-production and meaningful participation with residents, our local communities and partners which will help to build a more equitable future, addressing health inequalities, and ensuring that system collaboration underpins continuous improvements to population health and the integrated delivery of health and care services. The Working with People and Communities Strategy was developed in collaboration with partners and local people and through engagement it is clear that there is a system ambition to ensure co-production is at the heart of everything we do and that the five themes set out in the strategy should be tested against this ambition. The benefits of adopting truly embedded models of volunteering, peer support and strengths-based working lie in the reciprocal dynamic we can build – residents and local people are empowered to contribute, as well as to comment, which means that we are optimising the strengths of everyone across a truly whole system. The Committee discussed the report and a common theme identified was that further work is needed to understand the interfacing with other groups and that there was a need to include voluntary and faith groups specifically. Members agreed to receive a report at the next meeting regarding the planning for The Big Conversation which will be a set of conversations about the ICS priorities and what matters to residents in order enable codesign.

3.0 Risks and mitigations

3.1 The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

3.2 There are no additional risks arising as a result of this report.

Author: Katie McDonald, Governance Manager
Date: 23.12.2022

North East London
Integrated Care Board

Integrated Care Board Forward Plan

	25-Jan-23	29-Mar-23	31-May-23	23/28-Jun-23	26-Jul-23	27-Sep-23	29-Nov-23	31-Jan-23	27-Mar-23
Resident story									
Update on previous resident stories									
Chair and chief executive reports									
Chair's report									
Chief executive officer's report									
Governance									
Executive committee exception report									
QSI committee exception report									
FPI committee exception report									
PHI committee exception report									
Audit and risk committee exception report									
Workforce and remuneration committee exception report									
Approval of governance handbook									
Approval of the annual report and accounts									
Denistry, Optometry and Pharmacy (DOP) Delegation									
Approval of Corporate Objectives		TBD Mar/ May	TBD Mar/ May						
Finance and Performance									
Overview report									
Assurance									
Board Assurance Framework									
Quality									
Safeguarding annual reports (Adults, Children and LAC)	TBD	TBD	TBD		TBD	TBD	TBD	TBD	TBD
LeDeR Annual Report	TBD	TBD	TBD		TBD	TBD	TBD	TBD	TBD
CDOP Annual Reports	TBD	TBD	TBD		TBD	TBD	TBD	TBD	TBD
Safeguarding Policies	TBD	TBD	TBD		TBD	TBD	TBD	TBD	TBD
Review of Medical Safeguarding Provision Report	TBD	TBD	TBD		TBD	TBD	TBD	TBD	TBD
Proposal for Safeguarding System Board	TBD	TBD	TBD		TBD	TBD	TBD	TBD	TBD
Commissioner/ICB Statements for Provider Quality Accounts	TBD	TBD	TBD		TBD	TBD	TBD	TBD	TBD
System QSI report	TBD	TBD	TBD		TBD	TBD	TBD	TBD	TBD
Freedom to Speak Up - annual report									
Commissioner/ICB Statements for Provider Quality Accounts			TBD May/ Jul		TBD May/ Jul				
Strategy									
Integrated Care Strategy									
Updated working with people and communities strategy									
Joint forward plan (5 year plan)									
Clinical Care Leadership Strategy									
Part 2									
Finance deep dive									
StG H&W Hub - update on the outcome of the TIF bid									

**To be confirmed as to whether these can be approved by the QSI committee