North East London
Integrated Care Board

Newham ICB Sub Committee meeting

Friday 31 March 2023, 13.00 – 13.30pm
4th Floor Room F01, Unex Tower, Station Street, Stratford, E15 1DA
Chair: Colin Ansell

AGENDA

	Item	Time	Lead	Attached / verbal	Action required
1.0	**Welcome, introductions and apologies**	13.00	Chair	Verbal	Note
1.1	• Declaration of conflicts of interest			Attached	Note
1.2	• Questions from the public			Verbal *Pages 1 - 4*	Discuss/ Note
2.0	**Place Sub-Committee Terms of Reference**	13.10	Charlotte Pomery	Attached *Pages 5 – 47*	Discuss/ Approve
3.0	**Operating Plan update**	13.15	Saem Ahmed	Attached *Pages 48 – 75*	Note
4.0	**Finance report**	13.25	Sunil Thakker	Attached *Pages 76 - 95*	Note
5.0	**Any Other Business**	13.30	Chair	Verbal	Discuss
Date of next meeting **Health and Care Partnership Board:** **Friday 5th May 2023, Unex Tower**					

NHS North East London

- Declared Interests as at 20/03/2023

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
Karen Livingstone	Chief Executive of Newham Health Collaborative,	Newham Health and Care Partnership Newham ICB Sub-committee	Financial Interest	Newham Health Collaborative	Chief Executive of Newham Health Collaborative. We are a Primary Care provider - providing services to the residents of Newham for vaccination, General Practice appts in the evenings and weekends, some home visiting services, health checks and a range of primary care support services.	2020-10-05		Declarations to be made at the beginning of meetings
Martin Edobor	Clinical Lead for Digital Transformation (Newham)	Newham Health and Care Partnership Newham ICB Sub-committee	Non-Financial Professional Interest	Newham Training Hub	Clinical Lead for the Improvement and Innovation Hub	2020-09-01		
			Non-Financial Professional Interest	North Newham Primary Care Network	Clinical Director	2020-07-01		
			Non-Financial Professional Interest	Fabian Soicety	Chair	2020-12-01		
Muhammad Naqvi	Newham Primary Care Development Lead	Newham Health and Care Partnership Newham ICB Sub-committee Primary Care Collaborative sub-committee	Financial Interest	Woodgrange Medical practice	GP partner	2015-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	NHC - Newham GP Federation, Woodrange practice is a shareholder	GP partner	2015-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Frenford clubs for young people (registered charity/ voluntary organisation)	Trustee	2012-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Newham Health and Wellbeing Board	Co-Chair	2018-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Al-Sabr Foundation (registered charity/ voluntary organisation)	Trustee	2021-01-01		Declarations to be made at the beginning of meetings

Nadeem Faruq	Primary care lead Newham	Newham Health and Care Partnership Newham ICB Sub-committee	Indirect Interest	Market Street Health Group	Chair of Newham Health Colaboraitve and GP partner Market Street Health Group	2020-08-01	2021-12-24	Declarations to be made at the beginning of meetings
Tim Aldridge	A member of the ICS Executive Committee	ICS Executive Committee Newham Health and Care Partnership Newham ICB Sub-committee	Non-Financial Professional Interest	North East London Commissioning Partnership	I chair the North East London (Children's Commissioning Partnership) on behalf of the six Local Authorities that are members.	2018-01-01		
			Non-Financial Professional Interest	North East London Social Work Teaching Partnership	I chair the North East London Social Work Teaching Partnership on behalf of the Local Authorities that are members.	2019-01-01		

- Nil Interests Declared as of 20/03/2023

Name	Position/Relationship with ICB	Committees	Declared Interest
William Cunningham-Davis	Director of Primary Care Transformation, TNW ICP	Newham Health and Care Partnership Newham ICB Sub-committee Primary care contracts sub-committee Tower Hamlets ICB Sub-committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Richard Fradgley	Director of Integrated Care	Mental Health, Learning Disability & Autism Collaborative sub-committee Newham Health and Care Partnership Newham ICB Sub-committee Tower Hamlets ICB Sub-committee Tower Hamlets Together Board	Indicated No Conflicts To Declare.
Jo Frazer-Wise	Programme Lead for Integrated Community Care	Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Kelvin Hankins	Deputy Director of Unplanned Care	Newham Health and Care Partnership Newham ICB Sub-committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Indicated No Conflicts To Declare.
Marie Trueman-Abel	Head of Commissioning and Transformation / Interim Director of Delivery	Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Matthew Knell	Senior Governance Manager	City & Hackney ICB Sub-committee City & Hackney Partnership Board	Indicated No Conflicts To Declare.

		ICB Finance, Performance & Investment Committee Newham Health and Care Partnership Newham ICB Sub-committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	
Rima Vaid	OOH Clinical Lead	Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Sam Walker	Engagement and Community Communications Manager	Newham Health and Care Partnership Newham ICB Sub-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 ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Ryan Suyat	Borough Transformation Lead	Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Veronica Awuzudike	Healthwatch Newham Manager	ICP Committee Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Simon Reid	Director of Commissioning	Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Simon Ashton	Chief Executive Newham University Hospital	Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Colin Ansell	Chief Executive	ICB Population, Health & Integration Committee Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.
Jason Strelitz	Member of Newham Health and Care Partnership Board	Clinical Advisory Group Newham Health and Care Partnership Newham ICB Sub-committee	Indicated No Conflicts To Declare.

Newham Health and Care ICB sub-committee

31 March 2023

Title of report	Place Sub-Committee Terms of Reference
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery – Chief Participation and Place Officer
Contact for further information	charlotte.pomery@nhs.net
Executive summary	Colleagues across the Integrated Care System (ICS) partner organisations undertook a considerable amount of work in advance of the Integrated Care Board's (ICB) establishment on 1 July 2022 to determine the form and governance of the seven Place Based Partnerships. Broadly, the seven Place ICB Sub-Committees have consistent terms of reference, and the seven Partnership Boards have recognisably similar terms of reference but with variation to reflect local preferences, needs and vision. Building on the pre-existing relationships across north east London and the collaborations already in place, the intention for the Place governance in 'year one' was to make use of the new flexibilities in the legislation to establish a governance mechanism which would enable: (a) more formal integrated ways of working involving the broad range of partners across the ICS; and (b) the lawful and efficient delegation of functions based on the principle of subsidiarity. It was also important to ensure the governance arrangements enabled 'an evolutionary approach' where Places could take on increasing responsibility for aspects of the ICB's work overtime. This was consistent with national guidance which encouraged systems to 'build by doing.' The Place Mutual Accountability Framework ('MAF'), which has been developed through engagement, is now a significant step forward in this evolution. The MAF describes the activities intended to be undertaken at Place in a user-friendly, narrative form. The MAF will continue to be developed overtime, alongside the ICB's financial framework which is also important for understanding Places' responsibilities. The MAF will also need to be considered alongside an equivalent document proposed for the provider collaboratives, in order to make clear the delineation between the work done at Place and the work done by the collaboratives. However, the MAF gives a good level of clarity about the delegation of functions to Place and it is appropriate to

	reflect that in the Place governance as we move beyond year one. Accordingly, the terms of reference have been updated to tie in the MAF. This has been proposed in a way which avoids substantial redrafting or disruption to the arrangements which are now bedding in. The proposed changes made to the terms of reference are shown in tracked changes. But, in summary, the amendments involve adding a number of cross-references to the MAF throughout the document (especially at Annex 1) and adding references to the ICB's financial framework whilst recognising that the financial framework will continue to be developed during 2023/24. It was originally envisaged that Annex 1 would include a list of specific services that Places would have delegated commissioning responsibility. However, the suggested approach of linking the Annex to the MAF enables the arrangements for delegation to be updated from time to time without the need for revision to the seven sets of terms of reference. The approach enables an appropriate level of flexibility to continue the ongoing conversation about where and how functions are best exercised (e.g. taking into account any relevant learning from emerging practice across other ICSs and developing NHS England and Government policy). However, given the significance of the MAF in describing the delegation of functions to Place, any revision to it will require approval by the ICB. This has been secured by incorporating the MAF into the ICB's Governance Handbook. The MAF therefore has a similar status to the ICB's Scheme of Reservation and Delegation (SORD) or its Standing Financial Instructions.
Action required	Approval
Previous reporting	A first draft of the mutual accountability framework has been discussed for feedback at each place partnership and the ICB Executive Committee
Next steps/ onward reporting	Formal approval through ICB Board and update to the ICB governance handbook.
Conflicts of interest	None
Strategic fit	The terms of reference and mutual accountability framework is designed to support place partnerships to contribute to the achievement of all of the north east London's integrated care system's objectives: • to improve outcomes in population health and healthcare; • to tackle inequalities in outcomes, experience and access; • to enhance productivity and value for money; and • to support broader social and economic development.
Impact on local people, health inequalities and sustainability	North east London has a long history of successful pace-based working. Strengthening and spreading this across the integrated

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

NEWHAM

PLACE-BASED PARTNERSHIP

TERMS OF REFERENCE

Contents

INTRODUCTION

1. The following health and care partner organisations, which are part of the North East London Integrated Care System ('**ICS**') have come together as a Place-Based Partnership to enable the improvement of health, wellbeing and equity in the Newham area ('**Place**'):

    (a) Newham University Hospital ('**NUH**'), as part of Barts Health NHS Trust

    (b) East London NHS Foundation Trust ('**ELFT**')

    (c) London Borough of Newham

    (d) Newham Health Collaborative

    (e) The NHS North East London Integrated Care Board ('**the ICB'**)

    (f) Healthwatch Newham

    (g) [Newham CVS - TBC]

2. 'Place' for the purpose of these terms of reference means the geographical area which is coterminous with the administrative boundaries of the London Borough of Newham.

3. These terms of reference for the Place-Based Partnership incorporate:

    (a) As Section 1, terms of reference for the Newham Health and Care Partnership Board (the '**Partnership Board**'), which is the collective governance vehicle established by the partner organisations to collaborate on strategic policy matters and oversee joint programmes of work relevant to Place.

    (b) As Section 2, terms of reference for any committees/sub-committees or other governance structures established by the partner organisations at Place for the purposes of enabling statutory decision-making. Section 2 currently includes terms of reference for:

        - The Newham Sub-Committee of the North East London Integrated Care Board (the '**Place ICB Sub-Committee'**), which is a sub-committee of the ICB's Population Health & Integration Committee ('**PH&I Committee'**).

4. Section 2 contains arrangements that apply where a formal decision needs to be taken solely by a partner organisation acting in its statutory capacity. Where a committee/sub-committee has been established by a partner organisation to take such statutory decisions at Place, the terms of reference for that statutory structure will be contained in Section 2 below. Any such structure will have been granted delegated authority by the partner organisation which established it, in order to make binding decisions at Place on the partner organisation's behalf. The Place ICB Sub-Committee is one such structure and, as described in Section 2, it has delegated authority to exercise certain ICB functions at Place.

5. There is overlap in the membership of the Partnership Board and the governance structures described in Section 2. In the case of the Partnership Board and the Place ICB Sub-Committee, the overlap is significant because each structure is striving to operate in an integrated way.

6. All members of the Partnership Board or a structure whose terms of reference are contained at Section 2 shall follow the Seven Principles of Public Life (also commonly referred to as the Nolan Principles), which are: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

Section 1
Terms of reference for the Newham Health and Care Partnership Board

Status of the Partnership Board	1. The Partnership Board is a non-statutory partnership forum, which commenced its operation on 1 July 2022. It brings together representatives from across Place, who have the necessary authority from the partner organisation they represent to consider strategic policy matters and oversee joint programmes of work relevant to Place. 2. Where applicable, the Partnership Board may also make recommendations on matters a partner organisation asks the Partnership Board to consider on its behalf.
Geographical coverage	3. The geographical area covered will be Place, which for the purpose of these terms of reference is the area which is coterminous with the administrative boundaries of the London Borough of Newham.
Vision and ways of working	4. The overall purpose of the Partnership Board is to bring together partners across Place with the aims of: (a) Transforming the health and lives of people in Newham, reducing inequalities and organising services to match people's needs; (b) Developing joined up support and services that prevent people becoming ill; (c) Ensuring that services for people who are ill are high quality and can be accessed without delay. 5. The Partnership Board will work in a way which: (d) Involves, engages and co-produces with Newham residents; (e) Delivers through population-level health management approaches; (f) Delivers on the local vision for person-centred care close to people's homes. 6. The Partnership Board has agreed the following principles to guide its work, and the participation of its members: (g) Start from purpose, with a shared local vision; (h) Invest in building multi-agency partnerships;

(i) Nurture joined-up resource management;

(j) Embed effective place-based leadership.

Role of the Partnership Board

7. The Partnership Board provides a forum to:

(a) Enable oversight and escalation for the management and delivery of cross-partnership workstreams at Place;

(b) Draw on aligned organisational agendas;

(c) Escalate and address local issues and risk (e.g. to the partner organisations or to wider parts of the ICS as appropriate);

(d) Convene executive responsibility for Place planning and delivery of community development and integrated care provision.

8. The Partnership Board's principal tasks will include:

(a) Developing the community offer through programmes of work, including integrated models of care / transformation agenda;

(b) Demand capacity oversight;

(c) Developing and maintaining new ways of working: building effective relationships across Place, and furthering the strategic development of health and social care integration.

(d) Overseeing and monitoring design or task and finish groups who will be responsible for the delivery of projects set out in the Place-Based Partnership Plan.

9. The Partnership Board has the following core responsibilities:

(a) To set a local system vision and strategy, reflecting the priorities determined by local residents and communities at Place, the contribution of Place to the ICS, and relevant system plans including:

- the Integrated Care Strategy produced by the NEL Integrated Care Partnership ('**ICP**');
- the 'Joint Forward Plan' prepared by the ICB and its NHS Trust and Foundation Trust partners;
- the joint local health and wellbeing strategy produced by the Newham Health and Wellbeing Board ('**HWB**'), together with the needs assessment for the area;
- the Place Mutual Accountability Framework.[1]

[1] The Place Mutual Accountability Framework describes what NHS North East London ICB asks the seven Place ICB Subcommittees and wider Place Based Partnerships to have responsibility for and, in turn, what the Place

(b) To develop the Place-Based Partnership Plan for Newham which shall be:

- aimed at ensuring delivery of relevant system plans, especially those listed above;
- developed in conjunction with the governance structures in Section 2 (e.g. the Place ICB Sub-Committee);
- agreed with the Board of the ICB and the partner organisations;
- developed by drawing on population health management tools and in co-production with service users and residents of Newham.

(c) As part of the development of the Place-Based Partnership Plan, to develop the Place objectives and priorities and an associated outcomes framework for Place. A summary of these priorities and objectives can be found here.

(d) To oversee delivery and performance at Place against:

- national targets.
- targets and priorities set by the ICB or the ICP, or other commitments set at North East London level, including commitments to the NHS Long Term Plan.
- the Place-Based Partnership Plan, the Place objectives and priorities and the associated outcomes framework.

(e) To provide a forum at which the partner organisations operating across Place can routinely share insight and intelligence into local quality matters, identify opportunities for improvement and identify concerns and risk to quality, escalating such matters to the NEL ICS System Quality Group as appropriate. Meetings of the Partnership Board will give Place and local leaders an opportunity to gain:

- understanding of quality issues at Place level, and the objectives and priorities needed to improve the quality of care for local people.
- timely insight into quality concerns/issues that need to be addressed, responded to and escalated within each partner organisation through appropriate

Based Partnerships can expect the ICB to achieve for them. The framework needs to be read alongside the equivalent document that focuses on the role of the provider collaboratives which operate across the ICS area. The current versions of these frameworks are published in the ICB's Governance Handbook.

governance structures or individuals, or to the System Quality Group.

- positive assurance that risks and issues have been effectively addressed.
- confidence about maintaining and continually improving both the equity, delivery and quality of their respective services, and the health and care system as a whole across Place.

(f) To oversee the use of resources and promote financial sustainability.

(g) To make recommendations about the exercise of any functions that a partner organisation asks the Partnership Board to consider on its behalf.

(h) To support the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to:

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

(i) To support the North East London Integrated Care System to deliver against its strategic priorities and its operating principles, as set out here.

Statutory decision-making

10. In situations where any decision(s) needs to be taken which requires the exercise of statutory functions which have been delegated by a partner organisation to a governance structure in Section 2, then these shall be made by that governance structure in accordance with its terms of reference, and are not matters to be decided upon by the Partnership Board.

Making recommendations

11. Where appropriate in light of the expertise of the Partnership Board, the Partnership Board may also be asked to consider matters and make recommendations to a partner organisation or a governance structure set out in Section 2, in order to inform their decision-making.

12. Note that where the Partnership Board is asked to consider matters on behalf of a partner organisation, that organisation will remain responsible for the exercise of its statutory functions and nothing that the Partnership Board does shall restrict or undermine that responsibility. However, when considering and making

	recommendations in relation to such functions, the Partnership Board will ensure that it has regard to the statutory duties which apply to the partner organisation. 13. Where a partner organisation needs to take a decision related to a statutory function, it shall do so in accordance with its terms of reference set out in Section 2, or the other applicable governance arrangements which the partner organisation has established in relation to that function.
Collaborative working	14. The Partnership Board and any governance structure set out in Section 2 shall work together collaboratively. It may also work with other governance structures established by the partner organisations or wider partners within the ICS. This may include, where appropriate, aligning meetings or establishing joint working groups. 15. The Partnership Board may establish working groups or task and finish groups, to inform its work. Any working group established by the Partnership Board will report directly to it and shall operate in accordance with terms of reference which have been approved by the Partnership Board. *Collaboration with the HWB* 16. The Partnership Board will work in close partnership with the HWB and shall ensure that the Place-Based Partnership Plan is appropriately aligned with the joint local health and wellbeing strategy produced by the HWB and the associated needs assessment, as well as the overarching Integrated Care Strategy produced by the ICP. *Safeguarding collaboration* 17. The Partnership Board will also work in close partnership with the Newham Safeguarding Children Partnership and the Safeguarding Adults Board for Newham.
Chairing arrangements	18. The Chair of the Partnership Board will be the Interim Chief Executive of the London Borough of Newham, who is also is the Place Partnership Lead. 19. The Deputy Chair of the Partnership Board will be the Clinical / Care Director. 20. If for any reason the Chair and Deputy Chair are absent for some or all of a meeting, the members shall together select a person to chair the meeting.
Membership	21. There will be a total of 17[2] members of the Partnership Board, as follows:

[2] [TBC – dependent on number of Citizen Reps]

	Place (a) Place Partnership Lead (also the Interim Chief Executive of the London Borough of Newham) (b) Delivery Director for Newham (c) Clinical Care Director for Newham *London Borough of Newham* (d) Director of Adult Social Care and Public Health (e) Director of Children's Services (f) Director of Commissioning *NHS Trusts/Foundation Trusts* (g) Chief Executive, NUH (h) Medical Director, NUH (i) Executive Director of Integration, ELFT (j) Director of Specialist Services (Children's), ELFT *Primary Care* (k) Director of Primary Care, ICB (l) Place-Based Partnership Primary Care Development Clinical Lead (m) Chief Executive Officer, Newham Health Collaborative (n) Chair, Newham Health Collaborative *Others* (o) One representative of [Newham CVS] (p) One representative of Healthwatch Newham (q) [ ] citizen representative[s] 22. With the permission of the Chair of the Partnership Board, the members may nominate a deputy to attend a meeting of the Partnership Board that they are unable to attend. Each member should have one named nominee to ensure consistency in group attendance. Where possible, members should notify the Chair of any apologies before papers are circulated.
Participants	23. The Partnership Board may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This

shall include other colleagues from the partner organisations or across the ICS, professional advisors or others as appropriate at the discretion of the Chair of the Partnership Board.

Meetings

24. The Partnership Board will operate in accordance with the evolving ICS governance framework, including any policies, procedures and joint-working protocols that have been agreed by the partner organisations, except as otherwise provided below:

Quoracy

25. For a meeting of the Partnership Board to be quorate, at least six members will be present and must include:

    (a) Two of the members from the ICB;

    (b) Two of the members from the local authority;

    (c) One of the members from an NHS Trust or Foundation Trust;

    (d) One primary care member.

26. If any member of the Partnership Board has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

27. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Scheduling meetings

28. The Partnership Board will normally meet monthly.

29. Changes to meeting dates or calling of additional meetings will be convened as required in negotiation with the Chair.

30. At the discretion of the Chair, meetings may be held jointly with the Place ICB Sub-Committee.

Papers and notice

31. A minimum of seven clear working days' notice is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

32. On occasions it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair.

Virtual attendance

	33. It is for the Chair to decide whether or not the Partnership Board will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes. *Admission of the public* 34. Where the Partnership Board meets jointly with the Place ICB Sub-Committee in accordance with paragraph 30, its meetings shall be held in accordance with the Place ICB Sub-Committee's terms of reference in Section 2. Otherwise, the Partnership Board will ordinarily meet in private, unless the Chair determines otherwise. *Recordings of meetings* 35. Except with the permission of the Chair, no person admitted to a meeting of the Partnership Board shall be permitted to record the proceedings in any manner whatsoever, other than in writing. *Minutes* 36. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the Partnership Board, together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Chair. *Governance support* 37. Governance support to the Partnership Board will be provided by the ICB's governance team. *Confidential information* 38. Where confidential information is presented to the Partnership Board, all those present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.
Decision-making	39. The Partnership Board is the primary forum within the Newham Place-Based Partnership for bringing a wide range of partners across Place together for the purposes of determining and taking forward matters relating to the improvement of health, wellbeing and equity across the borough. It brings together representatives from across Place, who have the necessary authority from the partner organisation they represent to consider strategic policy matters and oversee joint programmes of work relevant to Place. 40. The Partnership Board does not hold delegated functions from the partner organisations, but each member shall have appropriate delegated responsibility from the partner organisation they represent

	to make decisions for their organisation on matters within the Partnership Board's remit or, at least, will have sufficient responsibility and be ready to move programmes of work forwards by holding discussions in their own organisation and escalating matters of importance. 41. Members will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view and reach agreement by consensus.
Conflicts of Interest	42. Conflicts of interests will be managed in accordance with relevant policies, procedures and joint protocols developed by the ICS, which shall be consistent with partner organisations' respective statutory duties and applicable national guidance.
Accountability and Reporting	43. The Partnership Board shall comply with any reporting requirements that are specifically required by a partner organisation for the purposes of its constitutional or other internal governance arrangements. The Partnership Board will also report to the ICP. 44. Members of the Partnership Board shall disseminate information back to their respective organisations as appropriate, and feed back to the group as needed. 45. The Partnership Board and the HWB will provide reports to each other, as appropriate, so as to inform their respective work. The reports the Partnership Board receives from the HWB will include the HWB's recommendations to the Partnership Board on matters concerning delivery of the Place objectives and priorities (see here) and delivery of the associated outcomes framework. The HWB will continue to have statutory responsibility for the joint strategic needs assessment and joint local health and wellbeing strategy. 46. Given its purposes at paragraph 9(e) above, the Partnership Board will regularly report upon, and comply with any request of the System Quality Group for information or updates on, matters relating to quality which effect the ICS and bears on the System Quality Group's remit.
Monitoring Effectiveness and Compliance with Terms of Reference	47. The Partnership Board will carry out an annual review of its effectiveness and provide an annual report to the ICP and to the partner organisations. This report will outline and evaluate the Partnership Board's work in discharging its responsibilities, delivering its objectives and complying with its terms of reference. As part of this, the Partnership Board will review its terms of reference and agree any changes it considers necessary.

Section 2
Terms of reference for the Newham Sub-Committee of the North East London Integrated Care Board

Status of the Sub-Committee	1. The Newham Sub-Committee of the North East London Integrated Care Board ('**the Place ICB Sub-Committee'**) is established by the Population Health & Integration Committee (the '**PH&I Committee'**) as a sub-committee of the PH&I Committee. 2. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Sub-Committee and may only be changed with the approval of the Board of the ICB ('the **Board**'). Additionally, the membership of the Sub-Committee must be approved by the Chair of the Board. 3. The Sub-Committee and all of its members are bound by the ICB's Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB. 4. These terms of reference should be read as part of the suite of terms of reference for the Newham Place-Based Partnership, including the terms of reference for the Newham Health and Care Partnership Board ('**the Partnership Board**') in Section 1, which define a number of the terms used in these Place ICB Sub-Committee terms of reference.
Geographical coverage	5. The geographical area covered will be Place, as defined in the Partnership Board's terms of reference in Section 1.
Purpose	6. The Place ICB Sub-Committee has been established in order to: (a) Enable the ICB to exercise the Delegated Functions at Place in a lawful, simple and efficient way, to the extent permitted by the ICB's Constitution and as part of the wider collaborative arrangements which form the Place-Based Partnership; (b) Support the development of collaborative arrangements at Place, in particular the development of the Place-Based Partnership. 7. The Delegated Functions which the Place ICB Sub-Committee will exercise are set out at **Annex 1** and described in further detail in the Place Mutual Accountability Framework which the annex refers to. 8. The Place ICB Sub-Committee, through its members, is authorised by the ICB to take decisions in relation to the Delegated Functions. 9. Further functions may be delegated to the Place ICB Sub-Committee over time, in which case Annex 1 ~~will~~ may be updated with the approval of the Board, on the recommendation of the PH&I Committee. The remit of the Place ICB Sub-Committee is also described in the Place Mutual

	Accountability Framework, which may be updated by the Board taking into account the views of the PH&I Committee. 10. The Delegated Functions shall be exercised with particular regard to the Place objectives and priorities, described in the Place-Based Partnership Plan for Newham, which has been agreed with the PH&I Committee and the partner organisations represented on the Partnership Board. A summary of the Place-Based Partnership's priorities and objectives can be found here. 11. In addition, the Place ICB Sub-Committee will support the wider ICB to achieve its agreed deliverables, and to achieve the aims and the ambitions of: (a) The Joint Forward Plan; (b) The Joint Capital Resource Use Plan; (c) The Integrated Care Strategy prepared by the NEL Integrated Care Partnership; (d) The HWB's joint local health and wellbeing strategy with the HWB's needs assessment for the area; ~~(d)~~(e) The Place Mutual Accountability Framework and the NHS North East London Financial Strategy and developing ICS Financial Framework; ~~(e)~~(f) The Place-Based Partnership Plan. 12. The Place ICB Sub-Committee will also prioritise delivery against the strategic priorities of the North East London Integrated Care System (see here) and its design and operating principles set out here. 13. In supporting the ICB to discharge its statutory functions and deliver the strategic priorities of the ICS at Place, the Place ICB Sub-Committee will, in turn, be supporting the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to: (a) Improve outcomes in population health and healthcare; (b) Tackle inequalities in outcomes, experience and access; (c) Enhance productivity and value for money; (d) Help the NHS support broader social and economic development. 14. The Place ICB Sub-Committee is a key component of the ICS, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.
Key duties relating to the exercise of the	15. When exercising any Delegated Functions, the Place ICB Sub-Committee will ensure that it acts in accordance with, and that its

Delegated Functions	decisions are informed by, the guidance, policies and procedures of the ICB or which apply to the ICB. 16. The Sub-Committee must have particular regard to the statutory obligations that the ICB is subject to, including, but not limited to, the statutory duties set out in the National Health Service Act 2006 and listed in **Annex 5**. In particular, the Place ICB Sub-Committee will also have due regard to the public sector equality duty under section 149 of the Equality Act 2010.
Collaborative working	17. In exercising its responsibilities, the Place ICB Sub-Committee may work with other Place ICB Sub-Committees, provider collaboratives, joint committees, committees, or sub-committees which have been established by the ICB or wider partners of the ICS. This may include, where appropriate, aligning meetings or establishing joint working groups. *Collaboratives* 18. In particular, in addition to an expectation that the Place ICB Sub-Committee and the Partnership Board shall collaborate with each other as part of the Place-Based Partnership, the Place ICB Sub-Committee will, as appropriate, work with the following provider collaborative governance structures within the area of the ICS: (a) The North East London Mental Health, Learning Disability & Autism Collaborative; (b) The Combined Primary Care Provider Collaborative; (c) The North East London Acute Provider Collaborative; (d) The North East London Community Collaborative;~~.~~ ~~(d)~~(e) The evolving Voluntary, Community and Social Enterprise Sector Alliance/Collaborative. 19. Some members of the Place ICB Sub-Committee may simultaneously be members of the above collaborative structures, to further support collaboration across the system. *Health & Wellbeing Board and Safeguarding* 20. The Place ICB Sub-Committee will also work in close partnership with: (a) The Health and Wellbeing Board and shall ensure that plans agreed by the Place ICB Sub-Committee are appropriately aligned with, and have regard to, the joint local health and wellbeing strategy and the assessment of needs, together with the NEL Integrated Care Strategy as applies to Place; and (b) The Safeguarding Adults Board for the Place established by the local authority under section 43 of the Care Act 2001~~1~~4; and

	(c) The Safeguarding Children's Partnership established by the local authority, ICB and Chief Officer of Police, under section 16E of the Children Act 2001~~4~~. *Establishing working groups* 21. The Place ICB Sub-Committee does not have the authority to delegate any functions delegated to it by the ICB. However, the Place ICB Sub-Committee may establish working groups or task and finish groups. These do not have any decision-making powers but may inform the work of the Place ICB Sub-Committee and the Place-Based Partnership. Such groups must operate under the ICB's procedures and policies and have due regard to the statutory duties which apply to the ICB.
Chairing and executive lead arrangements	22. The Place ICB Sub-Committee will be chaired by the Interim Chief Executive of the London Borough of Newham who is also the Place Partnership lead. The Chair is appointed on account of their specific knowledge, skills and experiences making them suitable to chair the Sub-Committee. 23. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference. 24. The Deputy Chair of the Place ICB Sub-Committee is the Clinical / Care Director. 25. If the Chair has a conflict of interest then the Deputy Chair or, if necessary, another member of the Sub-Committee will be responsible for deciding the appropriate course of action.
Membership	26. The Place ICB Sub-Committee members will be appointed by the Board in accordance with the ICB Constitution and the Chair of the ICB will approve the membership of the Sub-Committee. 27. The Place ICB Sub-Committee has a broad membership, including those from organisations other than the ICB. This is permitted by the ICB's Constitution and amendments made to the National Health Service Act 2006 by the Health and Care Act 2022. 28. The membership of the Place ICB Sub-Committee includes members drawn from the following partner organisations which operate at Place: (a) The ICB (b) NUH (c) ELFT (d) The London Borough of Newham (e) Newham Health Collaborative

(f) Healthwatch Newham

(g) [Newham CVS- TBC]

29. There will be a total of **13** members of the Place ICB Sub-Committee, as follows:

Place:

(a) Place Partnership Lead (also the Interim Chief Executive of the London Borough of Newham)

(b) Delivery Director for Newham

(c) Clinical Care Director for Newham

ICB:

(d) Director of Finance or their nominated representative

(e) Director of Nursing/Quality or their nominated representative

London Borough of Newham:

(f) Director of Adult Social Care and Public Health

(g) Director of Children's Services

NHS Trusts/Foundation Trusts:

(h) Chief Executive, NUH

(i) Executive Director of Integration, ELFT

Primary Care:

(j) Place-Based Partnership Primary Care Development Clinical Lead

(k) Chief Executive Officer, Newham Health Collaborative

Voluntary sector:

(l) One representative of [Newham CVS- TBC]

Healthwatch:

(m) One representative of Healthwatch Newham

30. With the permission of the Chair of the Place ICB Sub-Committee, the members, set out above, may nominate a deputy to attend a meeting of the Place ICB Sub-Committee that they are unable to attend. However, members will be expected not to miss more than two consecutive meetings. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.

	31. When determining the membership of the Sub-Committee, active consideration will be made to diversity and equality.
Participants	32. Only members of the Sub-Committee have the right to attend Sub-Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Sub-Committee. 33. The Chair may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion on particular matters.
Resource and financial management	34. The ICB has made arrangements to support the Place ICB Sub-Committee in its exercise of the Delegated Functions. Financial responsibilities of the Place ICB Sub-Committee are contained in the list of Delegated Functions in Annex 1, and further information about resource allocation within the ICB is contained in the ICB's Standing Financial Instructions and associated policies and procedures, which includes the NHS North East London Financial Strategy and developing ICS Financial Framework. ~~34.~~35. The Chair will be invited to attend the Finance Performance and Investment Committee where the Committee is considering any issue relating to the resources allocated in relation to the Delegated Functions.
Meetings, Quoracy and Decisions	~~35.~~36. The Place ICB Sub-Committee will operate in accordance with the ICB's governance framework, as set out in its Constitution and Governance Handbook and wider ICB policies and procedures, except as otherwise provided below: *Scheduling meetings* ~~36.~~37. The Place ICB Sub-Committee will aim to meet on a bi-monthly basis and, as a minimum, shall meet on four occasions each year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.[3] ~~37.~~38. At the discretion of the Chair, the Place ICB Sub-Committee may hold its meetings together with the Partnership Board, as part of an aligned meeting of the Place-Based Partnership. ~~38.~~39. The Board, Chair of the ICB or Chief Executive may ask the Sub-Committee to convene further meetings to discuss particular issues on which they want the Sub-Committee's advice. *Quoracy* ~~39.~~40. The quoracy for the Place ICB Sub-Committee will be six and must include the following of which one must be a care or clinical professional:

~~[3] In the first financial year of operation the Place ICB Sub-Committee is only expected to meet on three occasions.~~

(a) Two of the members from the ICB;

(b) Two of the members from the local authority;

(c) One of the members from an NHS Trust or Foundation Trust;

(d) One primary care member.

~~40.~~41. If any member of the Sub-Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

~~41.~~42. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Voting

~~42.~~43. Decisions will be taken in accordance with the Standing Orders. The Sub-Committee will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the Sub-Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Sub-Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

Papers and notice

~~43.~~44. A minimum of seven clear working days' notice is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

~~44.~~45. On occasions it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair.

Virtual attendance

~~45.~~46. It is for the Chair to decide whether or not the Place ICB Sub-Committee will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Admission of the public

~~46.~~47. Meetings at which public functions of the ICB are exercised will usually be open to the public, unless the Chair determines, at his or her discretion, that it would be prejudicial to the public interest by reason of

the confidential nature of the business to be transacted or for some other good reason.

~~47.~~48. The Chair shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business shall be conducted without interruption and disruption.

~~48.~~49. A person may be invited by the Chair to contribute their views on a particular item or to ask questions in relation to agenda items. However, attendance shall not confer a right to speak at the meeting.

~~49.~~50. Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the Place ICB Sub-Committee and others in attendance.

~~50.~~51. There shall be a section on the agenda for public questions to the committee, which shall be in line with the Integrated Care Board's agreed procedure as set out on our website here.

Recordings of meetings ~~and publication~~

~~51.~~52. Except with the permission of the Chair, no person admitted to a meeting of the Place ICB Sub-Committee shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Confidential information

~~52.~~53. Where confidential information is presented to the Place ICB Sub-Committee, all those who are present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.

Meeting Minutes

~~53.~~54. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the Place ICB Sub-Committee, together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Chair.

Legal or professional advice

~~54.~~55. Where outside legal or other independent professional advice is required, it shall be secured by or with the approval of the Director who is responsible for governance within the ICB.

Governance support

~~55.~~56. Governance support to the Place ICB Sub-Committee will be provided by the ICB's governance team.

	Conflicts of Interest ~~56.~~57. Conflicts of interest will be managed in accordance with the policies and procedures of the ICB and those contained in the Handbook and shall be consistent with the statutory duties contained in the National Health Service Act 2006 and any statutory guidance issued by NHS England.
Behaviours and Conduct	~~57.~~58. Members will be expected to behave and conduct business in accordance with: (a) The ICB's policies and procedures including its Constitution, Standing Orders and Standards of Business Conduct Policy which includes the Code of Conduct which sets out the expected behaviours that all members of the Board and its committees will uphold whilst undertaking ICB business. (b) The NHS Constitution; (c) The Nolan Principles. ~~58.~~59. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.
Disputes	~~59.~~60. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the Place ICB Sub-Committee in its capacity as a decision-making body within the ICB's governance structure, including uncertainty about whether the matter relates to: (a) a matter for wider determination within the ICS; or (b) determination by another placed-based committee of the ICB or other forum, such as a provider collaborative, then the matter will be referred to the Director who is responsible for governance within the ICB for consideration about where the matter should be determined.
Referral to the PH&I Committee	~~60.~~61. Where any decision before the Place ICB Sub-Committee is 'novel, contentious or repercussive' across the ICB area and/or is a decision which would have an impact across the ICB area, then the Place ICB Sub-Committee shall give due consideration to whether the decision should be referred to the PH&I Committee. ~~61.~~62. With regard to determining whether a decision falling within the paragraph above shall be referred to the PH&I Committee for consideration then the following applies: (a) The Chair of the Place ICB Sub-Committee, at his or her discretion, may determine that such a referral should be made.

(b) Two or more members of the Place ICB Sub-Committee, acting together, may request that a matter for determination should be considered by the PH&I Committee.

~~62.~~63. Where a matter is referred to the PH&I Committee under paragraph 61~~61~~60, the PH&I Committee (at an appropriate meeting) shall consider and determine whether to accept the referral and make a decision on the matter. Alternatively, the PH&I Committee may decide to refer the matter to the Board of the ICB or to another of the Board's committees/subcommittees for determination.

~~63.~~64. In addition to the Place ICB Sub-Committee's ability to refer a matter to the PH&I Committee as set out in paragraph 61~~61~~60:

(a) The PH&I Committee, or its Chair and Deputy Chair (acting together), may determine that any decision falling with paragraph 61~~61~~60 should be referred to the PH&I Committee for determination; or

(b) The Board of the ICB, or its Chair and the Chief Executive (acting together), may require a decision related to any of the ICB's delegated functions to be referred to the Board.

Accountability and Reporting

~~64.~~65. The Place ICB Sub-Committee shall be directly accountable to the PH&I Committee of the ICB, and ultimately the Board of the ICB.

~~65.~~66. The Place ICB Sub-Committee will report to:

(a) **PH&I Committee.** The PH&I Committee, following each meeting of the Place ICB Sub-Committee. A copy of the meeting minutes along with a summary report shall be shared with the Committee for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval.

And will report matters of relevance to the following:

(b) **Finance, Performance and Investment Committee.** Such formal reporting into the ICB's Finance, Performance and Investment Committee will be on an exception basis. Other reporting will take place via Finance and via NEL wide financial management reports.

(c) **Quality, Safety and Improvement ('QSI') Committee.** Reports will be made to the QSI Committee in respect of matters which are relevant to that Committee and in relation to the exercise of the quality functions set out here.

~~66.~~67. In the event that the Chair of the ICB, its Chief Executive, the Board of the ICB or the PH&I Committee requests information from the Place ICB Sub-Committee, the Place ICB Sub-Committee will ensure that it responds promptly to such a request.

	Shared learning and raising concerns ~~67.~~68. Where the Place ICB Sub-Committee considers an issue, or its learning from or experience of a matter, to be of importance or value to the North East London health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the ICB for onward referral to the PH&I Committee, the Chair or Chief Executive of the ICB, the Board, the Integrated Care Partnership or to one or more of ICB's committees or subcommittees, as appropriate.
Review	~~68.~~69. The Place ICB Sub-Committee will review its effectiveness at least annually. ~~69.~~70. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval: 30 September 2022 (Initial version by ICB Board on 1 July 2022)

Version: 2.0

Date of review: 1 April 2023

Annex 1 - ICB Delegated Functions

Commissioning functions

In addition to the specific activities set out in this Annex 1 below, ~~T~~the Place ICB Sub-Committee will have delegated responsibility for exercising ~~the ICB's commissioning functions at Place in relation to the following~~ functions described in the Place Mutual Accountability Framework at Place. These functions are referred to below as 'the **Place Commissioning Functions**'.

The Place Mutual Accountability is contained in the ICB's Governance Handbook and should be read alongside the equivalent accountability framework which describes the role of the provider collaboratives.

Where Place Commissioning Functions relate to a particular service they must be exercised in line with the ICB's relevant commissioning policy for that service.~~specified services (the '**Specified Services**'), in line with ICB policy:~~

~~[section to be completed by end of 2022 following confirmation]~~

Health and care needs planning

The Place ICB Sub-Committee will undertake the following specific activities in relation to health and care needs planning, through embedding population health management:

1. Making recommendations to the PH&I Committee in relation to, and contributing to, the Joint Forward Plan and other system plans, in so far as relates to the exercise of the ICB's functions at Place.

2. Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery at Place of the Joint Forward Plan, the Integrated Care Strategy and other system plans, in so far as they require the exercise of ICB functions.

3. Overseeing the development of service specification standards needed ~~at Place~~ in connection with the exercise of the Place Commissioning Functions and ~~for the Specified Services,~~ in line with relevant ICB policy.

4. Working with the Partnership Board on behalf of the ICB, to develop the Place-Based Partnership Plan including the Place objectives and priorities and a Place outcomes framework.

    The Place-Based Partnership Plan shall be developed by drawing on data and intelligence, and in coproduction with service users and residents of Newham. It is aimed at ensuring delivery of the Joint Forward Plan, the Integrated Care Strategy, the HWB's joint local health and wellbeing strategy and associated needs assessment, and other system plans.

    In particular, this shall include developing the Place priorities and objectives to be set out in the Place-Based Partnership Plan, and summarised here, and an associated outcomes framework developed by the Place-Based Partnership.

    The Place-Based Partnership Plan shall be tailored to meet local needs, whilst maintaining ICB-wide operational, quality and financial performance standards. It shall also be consistent with, and aimed at delivery of, the Place Mutual Accountability Framework at Place.

5. Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery of the Place-Based Partnership Plan, in so far as the plan requires the exercise of ICB functions.

6. Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery of the Place objectives and priorities, contained within the Place-Based Partnership Plan and summarised here, in so far as they require the exercise of ICB functions.

7. Overseeing the implementation and delivery of the HWB's joint local health and wellbeing strategy, in so far as the strategy requires the exercise of ICB functions.

Market management, planning and delivery

The Place ICB Sub-Committee will undertake the following specific activities in relation to market management, planning and delivery:

1. Making recommendations to the Board of the ICB / PH&I Committee in relation to health service change decisions (whether these involve commissioning or de-commissioning).

2. Approving commissioning policies ~~in relation to the Specified Services~~connected with the exercise of the Place Commissioning Functions, in line with ICB policy.

3. Approving demographic, service use and workforce modelling and planning, where these relate to ~~ICB commissioning functions being exercised at Place.~~the Place Commissioning Functions.

Finance

The Place ICB Sub-Committee will have delegated financial management and control, as detailed below and within the ICBs SFI's. The Finance, Performance and Investment Committee will continue to have oversight of NEL wide financial decisions, including where coordination/planning for the services concerned is best undertaken over a larger footprint. However, there will be ongoing dialogue in order to ensure a joined up approach, ensure financial sustainability, and as the NHS North East London Financial Strategy and ICS Financial Framework develop.

1. Plan and monitor the budgets delegated to the Place ICB Sub-Committee and take action to ensure they are delivered within the financial envelope.

2. The Sub-Committee will take shared responsibility, along with partners, for the health outcomes of their population, and will work with those partners to develop a shared plan for improving health outcomes and maintaining collective financial control.

3. Review and understand any variations to plan within the delegated budget and take appropriate action to mitigate these.

4. Oversee any required recovery plans in order to ensure financial balance is achieved at Place.

5. Ensure financial plans are triangulated with performance and quality.

6. Ensure any known financial risks are escalated to the ICB's Finance, Performance and Investment Committee and the ~~[~~ICS Executive~~]~~, as appropriate.

7. Review performance of the contracts within Place_~~, [in relation to the Specified Services,]~~ to ensure services and activity are being delivered in line with contractual arrangements.

8. Review and understand the financial implications of new investments and transformation schemes, and ensure there is sufficient funding across the life of the investment.

9. Oversee implementation of investments/transformation schemes, ensuring financial activity, Key Performance Indicators and required outcomes are delivered.

10. Review and agree any procurement decisions in relation to ~~the Specified Services~~services connected with the Place Commissioning Functions, as appropriate, in line with the ICB's Standing Financial Instructions and Procurement Policy.

11. Ensure financial decisions are taken in line with the ICB's Standing Financial Instructions and NHS North East London Financial Strategy and developing ICS Financial Framework.

12. In relation to financial risk share arrangements (including but not limited to section 75, 76 and section 256 agreements), the Place ICB Sub-Committee shall:

    - Review any current in year arrangements applicable to Place, ensuring that funding is spent appropriately in line with contractual agreements;

    - Review the risks and benefits of the allocation of funding and approve spend on pooled budgets based on recommendations from those leading the work and where all parties are in agreement;

    - Receive reports on the schemes funded through this mechanism to ensure it is delivering the expected outcomes and benefits;

    - Review the funding and arrangements for the subsequent financial year and ensure there are adequate governance and arrangements in Place that are consistent with other places across the ICB's area;

    - Review and make recommendations in relation to proposals for the ICB to enter into new agreements under section 75 of the 2006 Act with the local authority at Place. In accordance with the Constitution, any such arrangements must be authorised by the Board of the ICB.

Quality

The Place ICB Sub-Committee will undertake the following specific activities in relation to quality:

1. Providing assurance that health outcomes, access to healthcare services and continuous quality improvement are being delivered at Place, and escalate specific issues to the Population Health & Integration Committee, the Quality Safety and Improvement Committee and/or other governance structures across the ICS as appropriate.

2. Complying with statutory reporting requirements relating to the exercise of the Place Commissioning Functions~~Specified Services~~, in particular as relates to quality and improvement ~~of those services~~.

3. In addition, the Place ICB Sub-Committee will have the following responsibilities on behalf of the ICB at Place, in relation to quality:

    - Gain timely evidence of provider and place-based quality performance, in relation to the ~~Specified Services;~~ exercise of the Place Commissioning Functions at Place.

- Ensure the delivery of quality objectives by providers and partners within Place, including ICS programmes that relate to the place portfolio.
- Identify, manage and escalate where necessary, risks that materially threaten the delivery of the ICB's objectives at Place and any local objectives and priorities for Place.
- Identify themes in local triangulated intelligence that require local improvement plans for immediate or future delivery.
- Gain evidence that staff have the right skills and capacity to effectively deliver their role, creating succession plans for any key roles within the services being delivered at Place.
- Hold system partners to account for performance and the creation and delivery of remedial action/improvement plans where necessary.
- Share good practice and learning with providers and across neighbourhoods.

4. Ensure key objectives and updates are shared consistently within the ICB, and more widely with ICS and senior leaders via the ICS System Quality Group and other established governance structures.

Primary Care

The Place ICB Sub-Committee will undertake the following specific activities in relation to primary care:

1. To develop arrangements for integrated services, including primary care, through local neighbourhoods.

Communication and engagement with stakeholders

The Place ICB Sub-Committee will undertake the following specific activities in relation to communications and engagement:

1. Overseeing and approving any stakeholder involvement exercises proposed specifically in Place, consistent with the ICB's statutory duties in this context and the ICB's relevant policies and procedures. Such stakeholder engagement shall include political engagement, clinical and professional engagement, strategic partnership management and public and community engagement.
2. Overseeing the development and delivery of patient and public involvement activities, as part of any service change process occurring specifically at Place.

Population health management

The Place ICB Sub-Committee will undertake the following specific activities in relation to population health management:

1. Ensuring there are appropriate arrangements at Place to support the ICB to carry out predictive modelling and trend analysis.

Emergency planning and resilience

The Place ICB Sub-Committee will undertake the following specific activities in relation to emergency planning:

1. At the request of the any of the PH&I Committee or the Board, in relation to a local or national emergency, prepare or contribute to an emergency response plan for implementation at Place, coordinating with local partners as necessary.

FINAL DRAFT, FOLLOWING FEEDBACK

North East London Health & Care Partnership

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

Introduction

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

This draft document continues our discussion about what NHS North East London asks place partnerships to hold accountability for and, in turn, what the partnerships can expect NHS North East London to achieve for them. It will sit alongside an equivalent document that focuses on the role of provider collaboratives to help build our understanding of how the system overall will work best.

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

Zina Etheridge – Chief Executive Officer, NHS North East London

Background

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

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

As north east London's integrated care system, we are ambitious and actively draw on best practice locally and internationally. We are clear that we are moving beyond performance management to maximising value, and beyond our individual responsibilities to create a shared endeavour and mutual accountability for delivering benefit and opportunity for our residents. We are committed to continuous improvement and innovation across and with all partners, meaningful

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

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

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

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

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

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

Principles for working together as place, collaborative, and system

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

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

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

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

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

Neighbourhood working	The place partnership will facilitate strong connections within each neighbourhood, building integrated teams encompassing NHS and social care services, the wider local government offer, and community-led care and support. Along with a central role for primary care, including the primary care collaborative, this joined-up locality working will strengthen the integration of health and care and directly drive better local outcomes. ➢ *How NHS North East London will help* Where a lack of geographical coherence of primary care networks poses a challenge to neighbourhood working in a place, NHS North East London will work with the primary care collaborative and places to support and drive the alignment of footprints to maximise the impact of neighbourhood working.
Partnership working	The place partnership will promote and enable the widest possible view of partnership working. This means working beyond statutory health and care organisations and ensuring that representatives from (for example) the voluntary sector, housing, and police are actively involved in the work of the partnership. This wide view of partnership includes a default to meaningful engagement of, and co-production with, residents. The place partnership lead and NHS North East London will together support the development of the partnership as a high-functioning executive team. This includes the encouragement of peer collaboration and constructive debate between partners, along with transparency and candour about organisational challenges. The Place Partnership Lead, the Director of Partnerships, Impact and Delivery, the Clinical Lead, and the collaboratives' leads in each place will together manage the business of the partnership as well as leading co-production, innovation, and the sharing of best practice. On safeguarding specifically, there is an important opportunity to align the work of existing statutory forums with the work of the broader partnership. It is fully recognised that statutory arrangements for safeguarding across both adults and children are not directly affected by the development of the place partnership or the sub-committee of NHS North East London. However, the place partnership can play a vital role in facilitating the contribution of safeguarding leads' expertise into the broader agenda of the place partnership, including care model and pathway design. Equally, the place partnership can help to facilitate all partners' contribution towards additional preventative work across the safeguarding agenda. ➢ *How NHS North East London will help* NHS North East London will connect place partnerships with each other, including robust mechanisms to share learning and leading practice across place partnership leads, clinical and care professional leaders, and staff from all levels in partner organisations. NHS North East London will also provide elements of development support across the seven places, by agreement with the place partnership leads.
Local system flow	As the principal forum for local health, care and wellbeing partners, place partnerships are uniquely placed and have a critical role in addressing more immediate operational pressures whose resolution require input from multiple organisations. The place partnership lead will ensure that place-based mechanisms exist and are instrumental in ensuring that local people receive the right health and care support in the right time and in the right setting. Place partnerships will convene relevant partners as required to maintain consistent and adequate system flow, as well as to respond to periodic additional pressures. This will

	be with the support of the relevant commissioning and transformation teams from within NHS North East London and will ensure the pressures on all parts of the system are paid equivalent attention.
Mental health and wellbeing	The place partnership, working closely with provider collaboratives at place, will develop and, through its partners, deliver integrated services that enable residents with mental ill-health to live well in the community. This will focus on agreed priority cohorts and prioritise prevention and more equitable access to services. The place partnership lead will ensure a strong focus on the wider mental wellness agenda, including access to employment and access to community-based care and support networks, rather than our collective historic default to focus on the acute end of mental health services.
Babies, children, and young people	Place partnerships, working closely with provider collaboratives at place, will make sure that north east London's places are the best places for babies, children and young people to develop and grow. Place partnerships will take an all-age approach, requiring a focus on transitions into adulthood and parity between the needs of babies, children, young people, and adults, as the basis for sustainable long-term improvements to population health and wellbeing. The place partnership lead will support and enable the creation of a coherent approach to early years, adolescents, and young people up to the age of 24, bringing in partners from across the NHS, local government (families, education, housing), and community organisations, working with parents and families and building holistic support for all babies, children and young people.
Workforce	The place partnerships will lead local design of more integrated workforce models, based around neighbourhoods and focused on community delivery by a broad range of clinical and care professionals alongside VCSE. Place partnerships will also enable local employment by forging effective links with local education and training institutions. The place partnership lead will sponsor this work whilst participating in, and facilitating broader place contributions to, NEL-wide work on broader systemic issues relating to recruitment, retention, design of new roles, and skills development across north east London.
Long-term conditions	Place partnerships have a significant role in ensuring a strong focus on prevention and early intervention, convening work across collaboratives, places and system and facilitating the creation of health-promoting communities and neighbourhoods. Partnerships will support the co-ordination of end-to-end pathway responses for residents at risk of and experiencing long-term conditions, working at different geographies to facilitate the best outcomes for local residents and communities. Please see the annex for further detail.
Community-based care	Place has a significant role in co-ordinating care in the community, ensuring a strong focus on prevention and early intervention, working across collaboratives, places and system and creating health-promoting communities and neighbourhoods for all. Much of the focus will be on a multi-agency approach to Ageing Well, ensuring that north east London is a good place to age, for example with

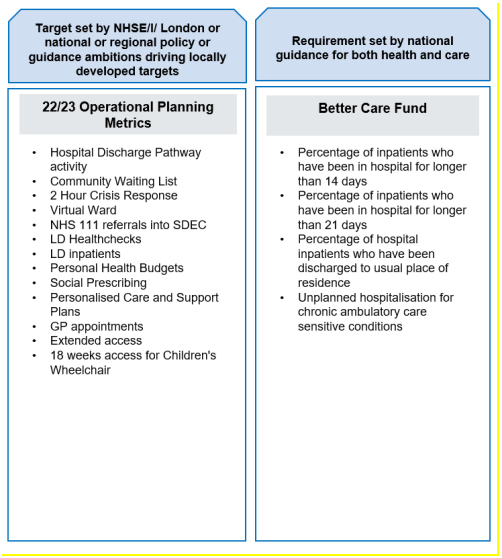
	dementia-friendly policies which could be met by the all-age approach supported by place partnerships. Place partnerships will seek to ensure residents can be supported at the end of their lives, dying with dignity in the place of their choice. This could include ensuring good information, advice, and guidance, palliative care at home, effective community support, and residential options are all available, reflecting the cultural and specific needs of our diverse populations. Place partnerships will ensure informal carers are well supported through the experience of end-of-life care for their loved ones. Please see the annex for further detail.
Learning disability and autism	Recognising the leadership role for local authorities in valuing people with learning disabilities and autism to lead fulfilling lives, place partnerships will bring together partners at a place level, including to improve the levels of employment, independent living, and quality of life for people with a learning disability. Place partnerships will enable good system working and ensure the needs of people with learning disabilities and autism are considered across all pathways. Place partnerships will work with all partners to seek to ensure people with learning disability and autism do not experience inequality of outcomes across any health or wellbeing domain, as reflected here and in performance and quality metrics. Place partnerships working across partners will be accountable for improving the rates of Learning Disability Health Checks carried out annually, and how the outcomes of these checks are followed through. Place partnerships will work with the Mental Health, Learning Disability and Autism Collaborative to ensure that Transforming Care responses are timely and support the principles of independent, community-based living for this cohort.
Carers	Place will play an active role in facilitating and joining up work across partners to ensure that carers are valued, supported to care, and able to enjoy fulfilling lives beyond their caring responsibilities. This will include developing a joint carers' strategy and action plan, as well as delivering on the NHSE metrics and deliver against specific targets on carer assessments, commissioning carer support agencies, etc. Place partnerships will work with local authority leads to ensure carers' strategies reflect wider system working and build awareness of the need for identification and support to carers to be system-wide. Place partnerships will deliver strengthened carers' offers that reflect the needs of their local communities and build best practice.
Homelessness	Recognising the leadership role of local authorities, place partnerships will be responsible for improving the health and wellbeing of those sleeping rough or facing homelessness by: • ensuring GP registration and primary care support to this cohort; • improving access to secondary and tertiary care as appropriate; • recognising the needs of the homeless population for all levels of support, care, and treatment across mental and physical health; and • co-ordinating local support to the street homeless population and participating in work led by local authorities work to improve their health and wellbeing outcomes.

Asylum seekers and refugees	Recognising the leadership role of local authorities, place partnerships will be responsible for improving the health and wellbeing of asylum seekers and refugees, including those accommodated in Home Office hotels, by: • ensuring GP registration and primary care support to this cohort; • improving access to secondary and tertiary care as appropriate; • recognising the needs of the asylum seekers for all levels of support, care, and treatment across mental and physical health; and • co-ordinating local health and wellbeing support to the asylum seeker and refugee population and participating in work led by local authorities to improve their health and wellbeing outcomes.
Person-centred care	Place partnerships will be held accountable for enabling person-centred care in their local area. This will include bringing together a range of initiatives that support residents and communities to be at the centre of decisions that are made around their care, reflecting the principle of 'Nothing about us, without us'. Ways of testing effectiveness in this area could include rates of satisfaction and levels of personal health budgets and direct payments in a specified area and for specific communities.
Health creation and primary prevention	Place partnerships will lead for ensuring that the wider determinants of health are effectively understood and influence approaches to all areas of accountability. Place partnerships will lead on the involvement of the whole local authority and wider partners to build an effective model for addressing wider determinants and their impacts on health and wellbeing. Place partnerships will be held accountable for supporting models to reduce health inequalities and improve health and wellbeing through a series of performance and quality metrics, attached.
Immunisations	Place partnerships are key in enabling uptake of immunisations across all communities in a local area. They will be accountable for the vaccination and immunisation rates of their local population, across children and adults and for routine and reactive vaccination programmes. Places will be required to ensure capacity for all vaccination and immunisations activity and to support take up with a focus on inequalities and ensuring equitable take up across all communities.

Accountability for improving performance and quality at place

Many of the performance and quality metrics – and related outcomes for residents – that NHS North East London is required to deliver can be achieved only through effective collaboration in place partnerships. Each partnership is working on a performance and quality metrics framework that will set out in greater detail the metrics for which place partnerships are responsible and will be held accountable, whether the lead is with the NHS, the local authority, or other partners. Such metrics could include for example those required by regulators such as the Care Quality Commission and Ofsted as well as individual partners.

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



How NHS North East London will help

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

Additional commitments from NHS North East London:

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

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

	• NHS North East London will also lead on working across partners to resolve issues that inhibit effective provision and sharing of data, including information governance, conflicting data sets, and unclear points of contact

Annex

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

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

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

- share best practice, identifying opportunities to work on a cross-borough basis and making pathways into secondary care as simple as possible.

North East London
Integrated Care Board

Newham ICB sub-committee

31 March 2023

Title of report	23/24 DRAFT submission operational planning report
Author	Saem Ahmed, Head of planning and performance
Presented by	Saem Ahmed, Head of planning and performance Sunil Thakker, Director of finance
Contact for further information	Saem Ahmed, Head of planning and performance saem.ahmed@nhs.net
Executive summary	• This document outlines the key requirements ICBs and providers are expected to deliver in 2023/24. • This paper will aim to provide the key headlines from the published guidance. And the key areas for community health services. • The first formal Operating Plan submission was made on Thursday 23 February. The national deadline for the final submission is 30 March. • The NHS priorities, national objectives and targets detailed in subsequent slides represent and are aligned to the Operating Plan which remains work in progress. Refer also to appendices more detail. • The 2022/23 NEL ICB underlying deficit totals £79.1m and forms the starting point of the Operating Plan. • For 2023/24, NEL ICB received core growth funding of £159.2m and declared an initial £18.4m deficit. • The 2023/24 NEL ICS position (including all Providers) is £197.7m deficit net of £225.2m efficiencies. All Providers have declared an initial deficit at submission which requires further work. • The financial outlook across NEL including Place is challenging with much work to be done to improve upon the financial situation. The outlook for Newham and all Places is still to be worked-up and forms part of the ongoing planning cycle. **This report is subject to change as we are we updating the trajectories for the final submission on the 30th March.**
Action / recommendation	The Board/Committee is asked to note this report.
Previous reporting	NEL FPIC Community Collaborative NEL EMT

Next steps/ onward reporting	As above
Conflicts of interest	N/A.
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
Impact on local people, health inequalities and sustainability	N/A
Impact on finance, performance and quality	Finance, performance and quality impacts provided on the paper.
Risks	Operational performance.

NHS
North East London

2023/24 Priorities and Operational Planning Update

31 March 2023

Saem Ahmed – Head of planning and performance

Introduction

- This document outlines the key requirements ICBs and providers are expected to deliver in 2023/24.
- This paper will aim to provide the key headlines from the published guidance. And the key areas for **community health services.**
- The guidance sets out **three key priorities**:

  1. Recover our core services and productivity.

  2. Make progress in delivering key ambitions in the NHS Long Term Plan.

  3. Continue to transform the NHS for the future.

- This paper will make particular reference to Community Health Services.
- Community health services (CHS) play a key role in the health and care system. They keep people well at home and in community settings close to home, and support people to live independently. When community services are delivered with universal personalised care, they can:
  - Reduce system pressures by supporting patients at home and in the community
  - Provide patients with greater choice and control, leading to improved patient experience outcomes, and
  - Reduce inequalities

23/24 NHS priorities

Recovering our core services and productivity	Delivering the key NHS Long Term Plan ambitions and transforming the NHS	Continue transforming the NHS for the future	Local empowerment and accountability
• Improve ambulance and A&E waiting times • Reduce elective long waits and cancer backlogs, and improve performance against core diagnostic standards • Make it easier for people to access primary care services, particularly in general practice	• Improve mental health services and services for people with a learning disability and autistic people • Prevention and the effective management of long-term conditions are key to improving population health and curbing the ever increasing demand for healthcare services • We need to put the workforce on a sustainable footing for the long term • To level up digital infrastructure and drive greater connectivity		• ICSs are best placed to understand population needs and are expected to agree specific **local objectives that complement the national NHS objectives** • They should continue to pay due regard to wider NHS ambitions in determining their local objectives – alongside place-based collaboratives

2023/24 national objectives and key targets

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
- Virtual Ward – 40 – 50 per 100,000 by December 2023, and occupancy at 80% by September 2023
- Community waiting list reduction
- 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 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 level

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)
- Value weighted elective activity target (as a % of 2019/20)–excludes secondary dental 109%
- Reduce outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024
- To increase productivity and meet the 85% day case and 85% theatre utilisation expectations

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

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

Use of resources
- Deliver a balanced net system financial position for 2023/24

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

Workforce
- Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise

Summary

- The first formal Operating Plan submission was made on Thursday 23 February. The national deadline for the final submission is 30 March.

- The NHS priorities, national objectives and targets detailed in subsequent slides represent and are aligned to the Operating Plan which remains work in progress. Refer also to appendices more detail.

- The 2022/23 NEL ICB underlying deficit totals £79.1m and forms the starting point of the Operating Plan.

- For 2023/24, NEL ICB received core growth funding of £159.2m and declared an initial £18.4m deficit inclusive of:
  - Price inflation £59.6m;
  - Negotiated growth £99.2m inclusive of a £23m investment pool which requires further work and to be reviewed against system wide cost pressures; and
  - ICB efficiencies £60.3m.

- The 2023/24 NEL ICS position (including all Providers) is £197.7m deficit net of £225.2m efficiencies. All Providers have declared an initial deficit at submission which requires further work.

- The financial outlook across NEL including Place is challenging with much work to be done to improve upon the financial situation. The outlook for Newham and all Places is still to be worked-up and forms part of the ongoing planning cycle.

ICB 23/24 Plan Submission

Item	£m
ICB Underlying Deficit 22/23	**79.1**
Funding	
Programme Growth	(184.7)
Convergence	25.5
Total Funding	**(159.2)**
Pricing	
Inflation	99.8
Tariff efficiency	(37.8)
Convergence	(25.5)
Better Care Fund	4.1
Continuing healthcare	8.4
Clinical Negligence Scheme for Trusts (CNST)	10.5
Total Pricing	**59.6**
Growth	
Underlying capacity recovery	17.9
Acute activity growth	21.2
Community activity growth	7.8
Prescribing activity Growth	1.5
Continuing healthcare activity growth (2.4%) & London price over national expectation (5.5%)	7.3
System wide cost pressures and investments including health inequalities funding	22.9
Mental Health Investment Standard	20.7
Total Growth	**99.2**
Efficiencies	
ICB Efficiency	(35.3)
System savings target (currently held by ICB)	(25.0)
Total ICB Efficiency Savings	**(60.3)**
Total ICB Planned Deficit	**18.4**

- ICB plan submission is an £18m deficit
- ICB received core funding growth of £159.2m
- The plan assumes Inflation in line with tariff and national assumptions (excluding convergence) total £85.1m.
- Following discussions at system CFOs - Growth assumptions have been applied at a contract level at 50% of national assumptions. This creates a £23m investment pool which needs to be reviewed against system wide pressures. Total growth £99m.
- Funds outside of this baseline include Covid (£15m) and ERF (£88m).
- Physical capacity / Virtual wards (£21m), Discharge funds (£8.5m) and SDF (£49m) are in addition to the baseline funding
- ICB efficiencies of £35m plus a system wide efficiency of £25m, and assumed £2m running cost efficiency

ICS 23/24 Plan Submission

	BHRUT	Barts Health	ELFT	Homerton	NELFT	ICB	Total ICS
	£m	£m	£m	£m	£m	£m	£m
23/24 Draft Plan							
Plan Deficit	**19.2**	**110.0**	**16.3**	**25.4**	**8.3**	**43.5**	**222.7**
Additional System Efficiency						**(25.0)**	**(25.0)**
Revised plan deficit	**19.2**	**110.0**	**16.3**	**25.4**	**8.3**	**18.5**	**197.7**
23/24 efficiency	(30.0)	(81.2)	(17.5)	(16.0)	(18.2)	(37.2)	**(200.2)**
Additional System efficiency						(25.0)	**(25.0)**
Total 23/24 Efficiencies	(30.0)	(81.2)	(17.5)	(16.0)	(18.2)	(62.2)	**(225.2)**
Efficiencies as a percentage of turnover*	3.7%	3.8%	2.9%	3.9%	3.4%	4.9%	**3.9%**
22/23 Forecast							
22/23 FOT M10 (Before applying £10.5m additional funding)	**18.0**	**19.0**	**(3.0)**	**0.0**	**0.0**	**1.0**	**35.0**
Total 22/23 Efficiencies	**(11.0)**	**(65.0)**	**(7.6)**	**(11.9)**	**(14.0)**	**(40.8)**	**(150.3)**
Efficiencies as a percentage of turnover*	1.4%	3.1%	1.3%	2.9%	2.7%	2.6%	**2.5%**
Change in Deficit	1.2	91.0	19.3	25.4	8.3	17.5	**162.7**
Change in Efficiencies	(19.0)	(16.2)	(9.9)	(4.1)	(4.2)	(21.5)	**(74.9)**
*ICB turnover based on programme spend less payments made to NEL providers.							

- System deficit submitted at £198m. This includes additional £25m system efficiency added to ICB position.
- Placeholders included in the plan for ERF funds, Mental Health Investment Standard and SDF
- Total system efficiency ask is £225m which is a £75m increase on the 22/23 requirement.
- As a percentage of turnover the total efficiency equates to 3.9% in 23/24

Immediate priorities to meet March deadline

- Urgently review elective performance in particular Barts Health and independent sector.
- Deficit needs to come down – focussed areas are productivity, agency spend and discretionary costs.
- Understand system opportunities for mutual aid where individual organisation targets are not being achieved.
- Agree process for investment.
- Conclude national discussions around Elective Recovery Fund (ERF) and apply to budget.
- Agree place financial positions – finalise System Development Fund (SDF) at Place include Place proportions.
- Triangulation between activity, performance, workforce and finance.

Next Steps – draft criteria for application of the £22.9m growth

- **Return on Investment (ROI), with more weighting towards earlier returns,** considering the total costs to the system (borne by all system partners) of new vs. old ways of working. Avoided future demand (e.g. from shorter LOS or fewer admissions) should be costed using best estimates of marginal cost of activity.
- **Impact on future acute demand (recurrent)**, recognising that a core goal of the ICS investment pool is to reduce growth in acute activity.
- **Impact on reducing inequity**, considering existing provision and outcomes, as well as future population need.
- **Likelihood of success**, including ensuring that realistic plans are in place for recruiting/sourcing the workforce needed (a greater risk appetite will be applied for smaller bids).
- **The risks associated with maintaining the status quo.**
- **Potential for scaling and spreading if successful** with greater weighting to those that could potentially be scaled, or where support is being sought for the spreading/scaling of an existing intervention.

Application of residual £22.9m

Cost Pressures 13.2.23	£m
Access Hubs Continuation	9.5
Revenue Implications of Capital Programme	1.0
BHR ISP FYE	3.3
Chief of Participation list	1.8
Fertility Case	2.1
Non recurrents removed . (If required as below)	9.8
Health Inequalities	6.6
MAB	4.6
Reach	2.4
PRU	0.3
Homerton crit care	0.0
Contract activity growth	0.0
Contract Over performance (i.e Drugs and Devices etc)	0.0
Underlying Deficit contribution	0.0
Operating Plan Requirements	0.0
	41.4

NR Expenditure	**£m**
Omnes backlog Payments - BHR	(0.2)
BHRUT diabetes - BHR	(0.1)
Lily Ward - BHR NR	(0.1)
Community ENT - Communitas -TNW	(2.0)
Community ENT - Diagnostics -TNW	(0.2)
Single Point of Access (SPA) -TNW	(3.4)
Covid - Home Monitoring - PC -TNW	(1.5)
Covid - Home Visiting - PC - double service -TNW	(0.8)
Covid - Homeless - ELFT -TNW	(0.9)
Covid - Homeless - NELFT -TNW	(0.1)
High Intensity User - ELFT -TNW	(0.2)
Mildmay Homelessness Service Contract -TNW	(0.5)
Total	**-9.8**

Ongoing CHS LTP priority commitments across 2023/24

Putting people in control of their own care through more personalisation

(Government Mandate to the NHS, 22/23)

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

(Fuller Stocktake)

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

(NHS Winter Letter)

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

(NHS Winter Letter)

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

(NHS Winter Letter)

Ensuring that patients receive personalised care tailored to their individual needs

(NHS Standard Contract 22/23)

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

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

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

(NHS England operating framework)

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

(NHS England operating framework)

Community services specific trajectories

There are three areas that NHS England have asked for planning trajectories for:

Urgent community response

A Count of 2-hour UCR first care contacts delivered within reporting quarter

Target: 70% within 2 hours

For this metric, a first care contact is the first care contact delivered after referral into the 2-hour UCR service for a 2-hour response

Community waiting list

Expected waiting list per system at the end of Q1, Q2, Q3 and Q4

Target: waiting list to be no greater than 2022-23

A waiting time starts from when the hospital or service receives the referral' and therefore this is when the patient joins a waiting list – and is not taken off that list until such time that they are treated or decide they do not wish to be treated.

Virtual ward

The indicator examines the reported virtual ward occupied capacity by the total available virtual ward capacity – the number of patients who can simultaneously managed within a virtual ward service – across all such existing services.

Target: 40-50 'beds' per 100k adult population (16 years and over) by December 2023 and 80% occupancy rate by September 2023.

Urgent community response

Our approach – assumptions underpinning our trajectory for drat submission

- We will align our expected demand to the A&E trajectories being developed by our acute trusts.
- We will apply 2% demo and non-demo growth to activity in line with the growth expected for A&E in 2023-24.
- We will sustain our 70% performance – already delivering against this target across NEL.

Key risks to note:

- There is no further investment into growing additional capacity into the current services.
- Therefore demand will need to be sustained around the current levels and no more than 2%.

Current performance:

- Delivering the 70% 2 hour response target

Proposed trajectory:

	Trajectories				
	2023-24 Q1	2023-24 Q2	2023-24 Q3	2023-24 Q4	Whole Year
Number of referrals that are in scope of 2 hour standard	2517	2535	2445	2499	9995

NHS NEL constantly meets and exceeds the 2-hour response time, the service is open 7 days a week across the core hours of 8am to 8pm. Our service meets the 9 core clinical conditions, as well as a wider range, this includes falls which is an integrated part of the service. The service has a well-established self-referral pathway, which is well known to patients already under community health services, we also have a direct pathway with Primary Care teams.

NHSE feedback on UCR

UCR: With the exception of City and Hackney, plan outlines current delivery of UCR services EHCH work outlined but limited detail on how referrals will increase from 111/999 and other referral pathways. Would be useful to provide further details on the following:

- how existing services plan to increase UCR referrals
- how EHCH services will support pathways for Falls and Frailty- with ambulance pathways, improved access to UCR services and wider social care comms/engagement.
- planned pathway development to increase self-referral pathways, Carer breakdown, TEC companies & Domiciliary Care.
- how SPA role could be developed to increase referrals from Ambulance services & 111
- how they plan to improve CSDS data submission and quality
- is there planning to ensure consistency in UCR service hours across all providers, including last referral times
- learning from 22/23 winter plans and how will support 23/24 service delivery, including how NEL plans to expand and develop PUSH model with LAS (22/23 winter funding initiative).

Community waiting list

Our approach – assumptions underpinning our trajectory for drat submission

- Providers will work up baselines that accurately reflect the waiting list position, the baseline by providers will be provided at place level to support and enable improvement discussions.
- Trajectories will be built on a revised baseline rather than what is currently being reported, and ***if possible*** reduce any long waiters more than 52 weeks (however, this is dependent on factors such as availability of workforce).
- Trajectory for 23/24 will be to hold the waiting list based on current levels, and for it to not get any greater than 2022-23.
- For the March submission, further work will need to be undertaken with 'places' and finance to address some 'wicked issues' within particular areas such as therapy services.

Key risks to note:

- Current reporting of community waiting lists through the monthly NHSE sitrep is not accurately reflecting waiting list positions, and therefore impacting on NEL performance. For example NEL are reporting the largest waiting list in England for children's services and this is being impacted by ELFT who are reporting circa 9000+ but we understand the true waiting list is around circa 1700.
- Particular challenges are around children's therapy services across NEL.
- Key issues impacting on waiting list are workforce, estate or demand and therefore needs further investigation.
- Data currently being reported by providers to NHSE is only at NEL or provider level, therefore difficult to enable place-based specific improvement discussions.

Current performance:

- Delivering the adults trajectory.
- Not delivering the children's trajectory.

NOTE: *Data reporting through the monthly NHS sitrep is not reflecting the accurate position and therefore impacting on performance*

Proposed trajectory:

NHS NEL Total				Quarter 1 2023/24	Quarter 2 2023/24	Quarter 3 2023/24	Quarter 4 2023/24
ICB	E.T.2a	Count	Number of CYP (0-17 years) on community waiting lists per system	8926	8740	8555	8374
	E.T.2b	Count	Number of Adults (18+ years) on community waiting lists per system	12781	12355	11910	11555

- The community waiting list is being reviewed and actioned through the community health collaborative and the place based partnerships.
- There are particular issues around data quality and consistency of reporting that is being actioned through the CHC.
- There are particular issues in children's therapy services which are being investigated and will be addressed through the CHC and place based partnerships.

Virtual ward

Our approach – assumptions underpinning our trajectory for drat submission

- Our trajectory will be to hold the position at 30 beds per 100,000 population by December 2023 based on current baselines (delivering the 40-50 beds per 100,000 population will be extremely challenging in NEL to deliver).
- Build trajectory based on current trends with the aim that 80% occupancy rate will be achieved in September 2023 and sustained beyond this.
- Ahead of the March submission we will explore whether there are other opportunities around increasing virtual ward capacity, and build this into the final submission.

Key risks to note:

- Delivering 40-50 per 100'000 beds across NEL will be challenging.
- Current beds is at 23 per 100'000 and this is at maximum availability, while further work is happening on potentially additional capacity which is being investigated.
- For 2022/23 NHSE/London accepted a lower trajectory than this, we will need to test whether this is the same for 2023/24 through the draft submission process.

Current performance:

- Currently delivering the 2022-23 trajectory.

Proposed trajectory:

	Apr 2023-Mar 2024 Average	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024
The number of patients on the virtual ward	281.5	245	269	294	318	343	367	392	416	441	441	441	441
The number of patients that the virtual ward is able to simultaneously manage	352	306	337	367	398	429	459	490	520	551	551	551	551
Virtual ward occupancy	79.98	80.07	79.82	80.11	79.9	79.95	79.96	80	80	80.04	80.04	80.04	80.04

The current baseline trajectory for virtual wards is based on 23 beds per 100,000 population in 2022/23 and then 30 beds per 100,000 population in 2023/24. The NEL target in Q4 2023/24 is to have in place 551 virtual ward beds across the system.

Current capacity stands at 174 beds throughout NEL, and at Q4 2022/23 the gap from the trajectory will be 38 beds. From 2023/24 the trajectory is to accelerate from 23 to 30 beds per 100,000. The control factors for the trajectory of patient numbers are the LOS (14 days) and Occupancy levels (80%).

We are not expecting substantive variances against previously submitted two-year trajectories for virtual ward capacity. However, we continue to have an ambition to grow bed provision in FY 23/24..

NHSE feedback on Virtual Ward

NEL feedback

- Currently has 23 beds per 100k, Expected trajectory of 30 beds per 100k for 23/24 (551). The current gap from their trajectory is 38 beds. Which is still 20% below target. Follow up: Why is there a shortfall of 10 beds per 100k in the trajectory for 23/24?
- Provide an explanation of how virtual wards will develop to avoid admission to hospital? Although there is insight into how this will be done. Focus is currently on early discharge over admission avoidance.
- Do the plans deliver the priorities set out in the planning guidance? Expected trajectory of 30 beds per 100k for 23/24. Partially: makes no narrative re: how they might achieve further scale. e.g. specialty engagement (comes through strongly in NWL plan)

London wide feedback

- None of the VW plans comment on the use of data to dynamically track patients either in hospital or in the community from point of view of early entry into VW / other admission avoidance or early discharge pathways.
- No reference to social care especially when considering community admission avoidance
- No mention of clear approaches to integration and/or using different aligned funding streams to deliver an integrated sustainable model
- Workforce development is referenced re: MDT
- Supporting clinical leadership, did not come through strongly in most plans.
- PCN Anticipatory Care Framework not mentioned as a dependency
- Little mention of use of UCP.
- Quality Governance not completely clear in all plans though not explicitly asked in the questions.
- Not seeing dynamic risk monitoring as part of plans.

Recap on timelines

- Draft submission deadline **23rd February 2023**
- NEL deadline for final draft **22nd March 2023**
- Provisional dates between **23rd March 2023 and 24th March 2023** – Triangulation meetings
- NEL Finance, Performance and Investment Committee (FPIC) **27th March 2023** for approval and sign-off
- National deadline **30th March 2023** 12pm for final submissions
- April 2023 – ICB Board

Appendix 1 – other trajectories submitted

Elective and diagnostics

ERF Target	NHSE H1 23/24 VWA Position	NHSE Proposed VWA Baseline 23/24	Draft Activity ONLY Plans 23/24 at 19/2/23
NEL	97%	109%	
Barts Health	89%	103%	**101%**
BHRUT	101%	109%	**109%**
Homerton	100%	109%	**108%**

Expected 65 week wait position for 2023/24

Our current Trust based draft trajectories for delivering the 65 week wait requirement are as follows: -

- Homerton Healthcare expected to **clear all waits** over 65 weeks by end of July 2023
- BHRUT expect to **clear all waits** over 65 weeks end of March 2024
- Barts Health expect to have around **60 people waiting** over 65 weeks at the end of March 2024.

Diagnostics

Activity levels in our diagnostic modalities exceed 100% of BAU, and our 23/24 plans will continue to sustain this, with the exception of endoscopy where we have successfully recovered the waiting list position and demand has reduced.

Current levels of activity against 19/20 BAU are:

MRI - 120%	CT – 114%	NOUS – 117%	Flexi sig – 86%
Colonoscopy – 106%	Gastroscopy – 111%	Echocardiography – 111%	

Key risks

- National workforce shortages in anaesthesia, surgery, and diagnostics impact on NEL's ability to convert premium cost workforce into substantive workforce and to recruit to new posts to enable full operation of CDC and TIF theatre capacity.
- Workforce initiatives in improving recruitment pipelines, via training academies and other schemes are not realised.
- New service capacity that is dependent on access to capital and revenue streams is not made available or impacted by inflationary and economic pressures.
- Schemes to increase capacity and improve productivity are not realised at least the rate of demand growth.
- Changes to local workforce agreements in radiography, to increase throughput and staff plans for 12-hour day/7 day week working across NEL are not realised by March 2025.
- Demand for endoscopy does not return to levels seen pre-pandemic impacting on ability to deliver 19/20 BAU activity levels.
- Mitigations include:
  - Reviewing opportunities to manage patient demand on elective & diagnostic services through enhanced engagement with primary care leaders, patient representatives and GPs. This includes designing new referral pathways and commissioning community based services.
  - Reviewing referrals pathways from within secondary and tertiary care providers.
  - Workforce programme for CDC and surgical hubs developed at NEL level to maximise impact of recruitment initiatives

Cancer

How will your system reduce the number of patients waiting over 62 days in line with the provider level requirements? **23/24 meets target**	• Our Cancer Alliance will work with providers to develop and implement action plans that will reduce the number of patients waiting over 62 days. Locally the Cancer Alliance have already created structures to enhance visibility and enable rapid response to challenges across the system; these have been proven to work during the most challenging periods of 2022/23. These structures will remain in place. • Enhancing validation resource, working with the independent sector and system wide solutions (including working with other programmes and networks such as Elective and diagnostic programmes) are some of the mechanisms that will be used.
How will your system 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? **23/24 meets target**	• The system will continue to utilise the Elective Diagnostic Centre and will expand the capacity across other modalities to meet expected levels of growth. • Expansion of the diagnostic capacity through the CDC programme. • The system will maintain the pathway changes for lower GI to include (referrals with a FIT test). • The use of teledermatology will continue at BHR and BH with the support of the Cancer Alliance. Whilst the system explores the use of AI technologies to further manage the demand challenges on the skin pathway. Insourcing at Homerton solutions will be used to facilitate the management of demand at HUH. • The Cancer Alliance will continue working with providers to implement and strengthen best practice times pathway. With a focus on those performing below the England FDS. •
How will your system increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028? **23/24 meets target**	• Working with the ICB and partners, the Cancer Alliance will explore commissioning of key services which will underpin progress on early diagnosis including non-specific symptoms pathways alongside.

To note for cancer: The backlog target of 1.95% set by NHSE for Homerton as part of the "fair share" requirement is not representative. Homerton have taken the growth and average into consideration to create their trajectory. This is still below the national 7% expected. The methodology used has been discussed with both regional and national teams

Urgent and emergency care

A&E (target 76% by March 2024)	Barts Health	BHUT	Homerton
Number of attendances at all type A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer.	36,457	20,713	9,155
Number of attendances at all type A&E departments.	47,915	26,892	11,269
Percentage of attendances at Type 1, 2, 3 A&E departments, excluding planned follow-up attendances, departing in less than 4 hours	**76.09**	**77.02**	**81.24**

Non-elective admissions		Apr 2019 - Mar 2020	Apr 2022 - Sep 2022	Apr 2023 - Mar 2024
BARTS HEALTH NHS TRUST	Number of specific acute non-elective spells in the period	128,992	41,534	118,732
	Number of specific acute non-elective spells in the period with a length of stay of zero days	48,087	8,785	60,368
	Number of specific acute non-elective spells in the period with a length of stay of one or more days	80,905	32,749	58,364
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	Number of specific acute non-elective spells in the period	64,441	33,957	69,342
	Number of specific acute non-elective spells in the period with a length of stay of zero days	20,811	11,634	23,472
	Number of specific acute non-elective spells in the period with a length of stay of one or more days	43,630	22,323	45,870
HOMERTON HEALTHCARE NHS FOUNDATION TRUST	Number of specific acute non-elective spells in the period	23,614	11,280	23,653
	Number of specific acute non-elective spells in the period with a length of stay of zero days	6,842	4,250	8,861
	Number of specific acute non-elective spells in the period with a length of stay of one or more days	16,772	7,030	14,792

Key risks

- The national target is for all hospital to deliver the 76% target of 4 hour waits by March 2024.
- As at week ending 19/02/2023 current performance for all types is:
  - Homerton 70.11%
  - Barts Health 63.15%
  - BHRUT 53.95%
- For the final submission the A&E and non-elective T&F group for the operating plan will be looking at:
  - What impact will our plans have on overall time spent in A&E for admitted and non-admitted patients?
  - other plan to expand services out of hospital and to avoid admission to hospital, attendance at A&E to support patients to leave hospital in a timely way other improvement programmes related to admission avoidance and reducing length or stay that are not covered by other narrative questions.
  - The G&A occupancy level that the ICS needs to maintain to achieve a minimum of 76% A&E performance against the four-hour standard (all-types).

Discharge pathway

We are working with our local authority partners in each place to deliver effective and timely discharge, step down and reablement services. Our discharge trajectories are based on expected growth in non-elective activity, anticipated improvements to discharge processes and investment in discharge capacity via the BCF. In 23/24 we are expecting to see a 2% increase in NEL demand, with some seasonal variation. We will therefore need to deliver an increase in step down capacity of at least 2%.

Discharge monies have been made available through the BCF and we are working with local authority partners to plan how to utilise these to deliver improved discharge processes and the required increase in capacity. The investment will be at a lower level than was given to systems via the 22/23 social care discharge fund – therefore this will not deliver a step up in capacity from current baseline, we will however try and utilise the money as effectively as possible by driving a home first approach and better management of the care home market.

Based on this -

- We are predicting that our daily discharge rate will increase at the same rate as the increase in NEL attendances.
- We are predicting that we will be able to (broadly) hold the current % of G&A beds occupied by people with no CTR at 10% most months, rising to 11% in the more pressured winter months.

ICB level hospital discharge	Oct-22	Apr 2023-Mar 2024 Average
The number of people discharged by location and discharge pathway per month	8,717	8,556
Hospital discharge pathway activity - pathway 0	7,564	84,515
Hospital discharge pathway activity - pathway 1	850	12,819
Hospital discharge pathway activity - pathway 2	130	1,796
Hospital discharge pathway activity - pathway 3	173	3,545

Barts Health NHS Trust			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	2023-24
E.T.3	Count/Total	The number of people discharged by location and discharge pathway per month	3,829	4,523	4,307	5,084	5,085	5,077	5,039	5,212	5,025	5,054	5,117	5,038	58,390
E.T.3a	Count	Hospital discharge pathway activity - pathway 0	3,097	3,693	3,599	4,336	4,484	4,427	4,459	4,560	4,381	4,362	4,470	4,371	50,239
E.T.3b	Count	Hospital discharge pathway activity - pathway 1	583	621	560	636	468	525	461	509	480	533	494	506	6,376
E.T.3c	Count	Hospital discharge pathway activity - pathway 2	101	122	98	73	82	72	71	68	74	73	71	73	978
E.T.3d	Count	Hospital discharge pathway activity - pathway 3	48	87	50	39	51	53	48	75	90	86	82	88	797

BHRUT			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	2023-24
E.T.3	Count/Total	The number of people discharged by location and discharge pathway per month	2,135	2,522	2,402	2,835	2,836	2,831	2,810	2,906	2,973	2,818	2,849	2,809	32,727
E.T.3a	Count	Hospital discharge pathway activity - pathway 0	1,665	1,967	1,873	2,211	2,212	2,208	2,192	2,267	2,342	2,198	2,211	2,191	25,537
E.T.3b	Count	Hospital discharge pathway activity - pathway 1	263	310	296	349	349	348	346	358	386	347	388	346	4,085
E.T.3c	Count	Hospital discharge pathway activity - pathway 2	45	53	50	60	60	59	59	61	59	59	45	59	669
E.T.3d	Count	Hospital discharge pathway activity - pathway 3	162	192	183	215	216	215	214	221	186	214	205	214	2,436

Homerton			Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	2023-24
E.T.3	Count/Total	The number of people discharged by location and discharge pathway per month	767	906	863	1,019	1,019	1,017	1,010	1,045	1,077	1,013	814	1,010	11,561
E.T.3a	Count	Hospital discharge pathway activity - pathway 0	578	683	650	767	768	766	761	787	834	763	621	761	8,739
E.T.3b	Count	Hospital discharge pathway activity - pathway 1	158	187	178	210	210	210	208	216	197	209	167	208	2,360
E.T.3c	Count	Hospital discharge pathway activity - pathway 2	10	12	11	13	13	13	13	14	18	13	5	13	149
E.T.3d	Count	Hospital discharge pathway activity - pathway 3	21	25	23	28	28	28	27	28	29	28	21	27	314

Primary care

	Plan Basis	Apr 2023-Mar 2024 Average
Planned number of General Practice appointments	76,394,314	6,366,193
Units of dental activity contracted	2,499,416	624,854
Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from general practice	50,000	12,500
Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS 111	26,380	5,276

Key risks

- Data Quality – Issues around data quality in relation to appointments in primary care
- The ability to manage increasing demand and expectation around access without unintended consequences impacting upon on quality
- Workforce capacity risk. PCNs are struggling to recruit into ARRS roles (lack of suitably trained staff). There are also a number of GPs and nurses nearing the age of retirement.
- Workforce capacity risk. PCNs are struggling to recruit into ARRS roles (lack of suitably trained staff). There are also a number of GPs and nurses nearing the age of retirement.
- Dental funds/allocations, contractual targets, increased need, inequalities and commissioning capacity

Primary Care planned number of appointments in general practice and CPCS referrals

Our plans are based upon the following assumptions;

- GP Appointment numbers have been derived by looking at the borough level population increase projections and then applying these to appointment activity data (for 2022) reported in the GPAD.
- patient turnover will remain at a similar level which is as high as 30% churn in some neighbourhoods
- continued support will be given to local systems to understand variation and inequalities through reviewing performance including data and coding at a practice level. This will inform development of local pathways in and out of primary and urgent care to scope the needs of local patient cohorts.
- practice workload is reduced as new clinical pathways are developed and aligned to capacity with demand for same day appointments
- there will be a continued increase of referrals to CPCS from 111 and the number of practices making referrals will increase from 93% to 100%.
- existing financial commitments and subsequent flows will remain the same throughout the year, taking seasonal variation into account.
- system recovery – we are assuming that there will be a successful continuation of elective and system-wide recovery that will continue to support primary care to manage demand.
- workforce rates will grow to meet the increased offer of appointments and that increased productivity will be sustained through quality improvement and digital acceleration with continued investment into supporting infrastructure, including best use of estate.
- Workforce plans are based on expansion of access through increased GP appointments and introduction of productivity improvements in general practice and are dependent on recruiting and retaining the primary are workforce

Dentistry – Increase in UDAs

- The recovery plan for Dentistry is iterative on the basis that many of the issues that affect access to dentistry are centred around the current contract and we have no ability to amend or flex this. That said, one aspect is the ability to allow practices to overperform up to 110% where capacity allows and remunerate them accordingly. Practices are contractually obliged to achieve 96% of their contracted activity to avoid the resource associated with underperformance being ‘clawed back.

Mental Health

Metric	2022/23 Q3 Performance	2023/24 Q4 Trajectory	Commentary
Inappropriate Out of Area Placement Bed Days	155	0	• Compliant trajectory submitted • Zero bed days in 2023/24
Access to IAPT Services	12,178 *(23.94%)*	14,244 *(28.00%)*	• Access rate growth but non-compliant trajectory submitted • Unable at this point to commit sufficient financial resources to achieve full compliance given UEC pathway pressures. • Speed of recruitment would make also full year compliance problematic.
Estimated Dementia Diagnosis rate	59.72%	66.7%	• Compliant trajectory submitted • 66.7% across 2023/24
Women accessing Perinatal Mental Health services	2,225 *(6.95%)*	2,803 *(8.76%)*	• Access rate growth but non-compliant trajectory submitted • Unable at this point to commit sufficient financial resources to achieve full compliance given UEC pathway pressures. • Speed of recruitment would make also full year compliance problematic.
Community access for adults with SMI	54,981	64,798	• Compliant trajectory submitted • 5% increase by the end of 2023/24
Access to CYP services	21,515 *(46.22%)*	24,322 *(52.25%)*	• Access rate growth but non-compliant trajectory submitted • CYP Urgent Care expansion is not predicted to increase access • Some places need to expand duration of treatment to meet rising acuity. This will not increase access.

Workforce

- Agency cap not achieved by HUH, ELFT and NELFT
- Soft FM in-housing - £63m
- Agency cap - £140m, current plan £154m current run rate c. £190m

Newham ICB sub-committee

31 March 2023

Title of report	Newham Place Month 10 2022-23 Financial Reporting
Author	Vincent Heneghan, Head of Finance
Presented by	Sunil Thakker, Director of Finance
Contact for further information	Sunil.Thakker@nhs.net Vincent.Heneghan@nhs.net
Executive summary	**Key issues** • The attached presentation outlines the year-to-date and forecast position of the ICS, ICB and the position on adult social care at London Borough of Newham (LBN). • The ICS have reported an unfavourable system variance to plan at month 10 of £43.2m, primarily due to inflationary pressures and slower than planned delivery of savings and cost improvement. However, the forecast position is outturn to plan. • LBN have reported a £13.7m overspend at Month 10 of 2022/23. • Additional allocations (transformation and SDF funding) have been allocated to Newham. It is expected that these will break even at year end. However, further updates will be given on the progress of schemes to future meetings. **Recommendations** • Note the contents of the report
Action required	Note
Previous reporting	N/A
Next steps/ onward reporting	Regular updates to Newham Healthcare Partnership Board
Conflicts of interest	No conflicts of interest
Strategic fit	Which of the ICS aims does this report align with? • To enhance productivity and value for money
Impact on local people, health inequalities and sustainability	Update on financial sustainability of the system
Impact on finance, performance and quality	Financial plans are set of the resources available. The report provides an update on financial performance.
Risks	Risks are flagged in the health system. Key risks flagged are inflation, efficiencies and ICB run rate pressures within CHC and prescribing. Further system risk has been flagged in relation to workforce and pay pressures.

1.0 Introduction

1.1 The month 10 finance report provides the partnership board with an update of the ICB and wider NEL system financial position. In additional information is included on spend that can be identified to Newham place.

1.2 The Partnership Board is asked to note the information in the presentation attached to this report. The attachment will be available to the committee electronically and a hard copy can be provided on request.

1.3 The report provides a summary of the month 8 financial position and describes the drivers of spend and risks to the reported position.

1.4 This paper links to the requirement to deliver a break even position.

2.0 Key messages

2.1 The NEL health system and London Borough of Newham (LBN) are operating in an economic climate facing significant pressures and uncertainty. As a result of the current pressures the year to date position for health partners is a deficit of £44.2m. At month 10 the health system is forecasting a £35m deficit at year-end.

LBN are reporting an overspend of £13.7m in Adult Social Care.

3.0 Month 10 Reporting

3.1 The attached presentation details the financial position of the ICB and NEL health partners and LBN. It flags pressures in the system in relation to inflation, efficiencies and run rate pressures in continuing healthcare, prescribing and discharge schemes.

3.2 The attached presentation details areas of spend that are identifiable by place and gives detail of budgets. Additionally, further information is provided on key drives of spend such as discharge and continuing healthcare. This information will continue to be developed and regular financial updates will be given to the partnership board.

4.0 Risks and mitigations

4.1 Total risks across the NEL health system is £53m. It is expected that a large proportion of these will be mitigated leaving a net risk of £24.5m.

4.2 The ICB has flagged activity and price risks with CHC and prescribing. All organisations are flagging run rate risks with regards to the delivery of efficiencies. Additionally, NEL providers are flagging inflation, workforce pressures and elective recovery pressures.

4.3 Mitigations are being driven through the financial recovery group and throughout each of the organisations

4.4 LBN have flagged risks see slide deck.

5.0 Conclusion / Recommendations

5.1 The partnership board is asked to note the information in the attached document.

6.0 Attachments

6.1 List any attached papers/appendices - Month 10 2022-23 Financial Reporting

7.0 End

7.1 Vincent Heneghan, Head of Finance NEL ICB.

NHS
North East London

Newham Place
Month 10 2022-23 Financial Reporting

Meeting name: Newham Partnership Board

Presenter: Sunil Thakker

Date: 31.03.23

Contents

ICB & Health System Summary

- **ICB and Health System Providers**
- In summary at month 10, the ICB reported a year-to-date overspend of £1m.
- System providers have a year-to-date overspend of £43.2m, making the total system overspend £44.2m.
- At month 10, there has been a movement from a forecast break-even position to a forecast deficit of £35m. Additionally, it is expected that if this position is achieved it will result in NHSE releasing £10.5m resource. This has been assumed in the month 10 position and the forecast outturn reported is, therefore a deficit of £24.5m.
- The system and ICB are in the process of developing plans to offset the ongoing risks and develop a 5 year financial plan.

Financial Governance at Place

The delegation of financial authorisation and governance for the current financial year is contained within the 2022/23 standing financial instructions and scheme of reservation and delegation. The SORD and SFIs, as with all governance, apply to all places and central teams.

- These documents detail that place based committees only have authorisation to approve financial spend on areas that have been formally delegated
- Within the current SORD the place has (where delegated) authority for business cases which only cover one place based partnership, procurement and contracting and section 75 agreements.
- Current year section 256 agreements will come under the governance that is included in the agreement.
- No other committee has financial authorisation within the Place.
- The authorisation only applies to one place, if more than one place is involved in the financial decision then it becomes a NEL decision.
- Section 75 agreements need to be signed off by the ICB Board – this is from national guidance, however the place then has authorisation as detailed in the terms of reference for the committee and within the agreement.

Financial year 2023/24

There is currently a review underway for the SFIs and SORD for next financial year – this will take into account the financial strategy and mutual accountability framework.

NEL Wide Executive Summary - Health

Month 10 ICS Position - YTD £44.2m deficit against plan.

Provider deficit position of £44.7m, ICB deficit of £1m. At month 10 a planned deficit of £1.5m, resulting in a variance to plan of £44.2m. Main drivers are inflation, under delivery of efficiency target and ICB run rate pressures in CHC and prescribing.

Month 10 I&E - YTD - ICS

		YTD	Forecast
Target	£m	(1.5)	0.0
Actual	£m	(45.7)	(24.5)
Variance Surplus / (Deficit)	**£m**	**(44.2)**	**(24.5)**

Financial Risks to the ICS Forecast outturn.

Gross risks of £53m at month 10.

Main drivers – inflation and delivery of efficiencies at Bart's and BHRUT.

System mitigations in the form of an expected additional resource from NHSE, resulting in a system reported year-end deficit of £24.5m

ICS Risk

		Gross Risk	Post Mitigations
Provider risk	£m	(53.0)	(35.0)
System Mitigation	£m	0.0	10.5
ICB Risk	£m	0.0	0.0
Total	**£m**	**(53.0)**	**(24.5)**

NEL ICB – YTD deficit of £1m against plan.

This position has moved due to the reversal of the prior month surplus generated by ERF claw back from providers.

ICB ongoing run rate pressures, relating largely to CHC, prescribing, under delivery of efficiencies, offset by non-recurrent mitigations.

Month 10 I&E NEL ICB

		YTD	Forecast
Target	£m	0.0	0.0
Actual	£m	(1.0)	0.0
Variance Surplus / (Deficit)	**£m**	**(1.0)**	**0.0**

ICS Delivery of Efficiencies

Year-to-date efficiency plan across the system of £151m. Actual delivery of £117.5m, resulting in year-to-date slippage of £33.5m.

The ICB reports break-even against the delivery of efficiencies at year-end, providers are reporting year-end slippage of £35.7m.

ICS Efficiencies

		YTD	Forecast
Target	£m	151.0	186.0
Actual	£m	117.5	150.3
Variance	**£m**	**(33.5)**	**(35.7)**

NEL Wide Financial Summary Month 10 – Health

Month 10 Summary Position

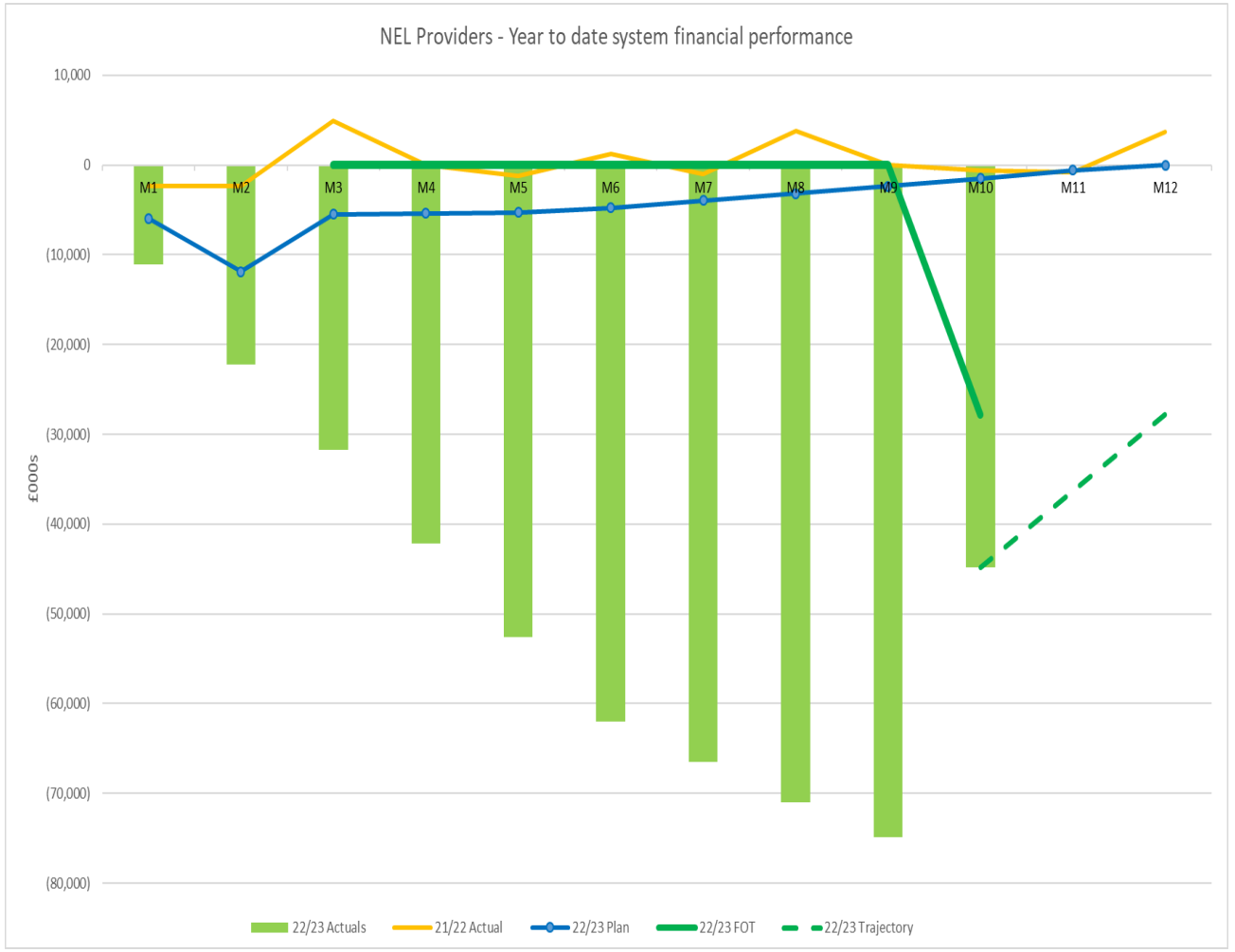
- The year-to-date ICS position against the plan is a **deficit of £44.2**. This is made up of a provider deficit of £43.2m and ICB deficit of £1m.
- The ICB has ongoing run rates in relation to CHC and prescribing which are offset by programme underspends and non-recurrent mitigations.
- There has been a change in reporting between months 9 and 10 which means that the impact of the ERF clawback has been reversed (prior to month 10 this was reported as an underspend in the ICB position and an overspend against the providers position).
- Across the NEL **health system** there are overspends reported due to slippage on the delivery of efficiencies.
- **System providers** are reporting pressures in relation to inflation and staffing.
- At month 10 the **forecast position is a reported deficit of £24.5m.** It has been agreed with regulators that the final reported year-end position will be £35m (£1m ICB and £34m system providers). Achievement of this will attract an additional resource from NHSE, resulting in a final year-end deficit of £24.5m (break-even ICB with a £24.5m system provider deficit). It is expected that the resource will be received in month 12, however it has been assumed as an income source in the forecast at month 10.

	Year to date			Forecast Outturn		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Total Provider Position	**(1.5)**	**(44.7)**	**(43.2)**	**0.0**	**(24.5)**	**(24.5)**
ICB (CCG) Position	0.0	(1.0)	(1.0)	(0.0)	0.0	0.0
Total System Position	**(1.5)**	**(45.7)**	**(44.2)**	**0.0**	**(24.5)**	**(24.5)**

Organisations	Year to date			Forecast Outturn		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
BHRUT	(0.9)	(21.3)	(20.5)	0.0	(14.6)	(14.6)
Barts Health	0.0	(20.3)	(20.3)	0.0	(12.9)	(12.9)
East London NHSFT	(0.5)	(0.1)	0.4	0.0	3.0	3.0
Homerton	(0.1)	(2.8)	(2.6)	0.0	0.0	0.0
NELFT	0.0	(0.2)	(0.2)	0.0	(0.0)	(0.0)
Total NEL Providers	**(1.5)**	**(44.7)**	**(43.2)**	**0.0**	**(24.5)**	**(24.5)**
NEL ICB	0.0	(1.0)	(1.0)	(0.0)	0.0	0.0
NEL System Total	**(1.5)**	**(45.7)**	**(44.2)**	**0.0**	**(24.5)**	**(24.5)**

Provider Year to Date Performance and Forecast position

- This graph compares 2022/23 actuals to 2021/22 actuals. It also compares it to the planned position and shows the trajectory required to achieve the revised forecast overspend of £24.5m.
- This data is for Barts, BHRUT, ELFT, Homerton and NELFT. Individual provider performance can be found in the appendices.
- The graph shows the month by month deficit position. At month 10 the year-to-date provider deficit is £44.7m. The reduction in deficit from previous months is in part as a result of the revised treatment of ERF.
- The trajectory to year-end shows a year-end deficit of £24.5m.
- Discussions have taken place across the system and with regulators and Barts and BHRUT have moved from a break-even position to report a forecast deficit in month 10.



Financial Position Month 9 – London Borough of Newham

- This position reflects the use of £9m contingency budgets, held back at the start of the year to mitigate any cost or demand pressures
- It does not include the planned use of £4.2m reserves, which has brought the forecast overspend to £9.5m
- Significant pressures have arisen this year in
  - Temporary Accommodation (part of Inclusive Economy and Housing)
  - Central budgets to cover an unexpectedly high pay award to council staff

Directorate	2022/23 Budget (£m)	2022/23 Forecast (£m)	2022/23 Variance
Children and Young People	108.6	110.2	1.6
Inclusive Economy & Housing	20.4	26.8	6.4
Adults & Health	102.8	104.4	1.6
Environment and Sustainable Transport	20.4	22.5	2.1
Marketing	7.3	7.3	-
Digital	11.5	12.7	1.2
Transformation	1.4	1.4	-
Resources	1.6	1.4	(0.2)
RMS	-	0.2	0.2
oneSource Non Shared	(6.3)	(5.3)	1.0
oneSource Shared	1.2	3.2	2.0
Central Budgets - General	57.9	55.7	(2.2)
TOTAL	**326.8**	**340.5**	**13.7**

Financial Risks, Mitigations and Efficiencies – Health

- The table below shows the financial risks and delivery of efficiencies reported to NHSE at month 10.

		Risk		Efficiencies			
Organisation / System wide	**Description of risk**	**Potential Impact before mitigations £m**	**Potential Impact after mitigations £m**	Year to date Plan £m	Year to date Actual £m	Year to date Variance £m	Forecast Variance £m
NHS Providers - Barts, BHRUT	Efficiency, inflation, NHS income, pay award, temporary staffing	(53.0)	(35.0)	118.0	84.5	(33.5)	(35.7)
North East London ICB	Run rate risk to break even position, CHC and prescribing	0.0	0.0	33.0	33.0	0.0	0.0
System Wide	National funding for hitting stretch target	0.0	10.5				
Total Risk - Health		**(53.0)**	**(24.5)**	**151.0**	**117.5**	**(33.5)**	**(35.7)**

Risks and Mitigations

- At month 10 the only organisations with outstanding risks are BHRUT and Bart's. These risks relate to delivery against the efficiency target and ongoing risks in relation to excess inflation. The gross risk of this is estimated to be £53m. System wide discussions and discussions with the regulators have taken place and whilst there are some identified mitigations it is likely that there will be an unmitigated risk to the financial position of £35m. Against this risk there is £10.5m national funding available for hitting the stretch target. This brings the overall risk after mitigations to £24.5m.
- Other providers and the ICB have identified mitigations that means there is no further risk to their 2022-23 reported position.
- However, within the ICB some of the mitigations have been non-recurrent. This means that there is an impact moving forwards into 2023/34 and the expected underlying start point for the 2023/24 plan is an underlying deficit of circa £79m. Additionally, the release of in-year benefits and accruals means that the total cash requirement in 2022/23 is £109m in excess of the estimated cash drawdown limit for the year.

Financial Risks, Mitigations and Efficiencies (continued) - Health

- The ICB CPFO has constituted a finance recovery group working 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 5 year system financial plan

Efficiencies

- The total year-to-date planned efficiency target for the NEL system is £151m.
- The year-to-date efficiencies delivered across the system is £117.5m, resulting in slippage across the system of £33.5m.
- The ICB is forecasting full delivery of efficiencies, with providers expecting year-end slippage of £35.7m.
- There are financial risks inherent in this assumption both in terms of delivery and the split of recurrent and non-recurrent delivery.

Financial Risks and Mitigations – London Borough of Newham (TBC)

Directorate	Risk	Potential Annual Impact (where estimated) 2022/23 [£]
Central Budgets including Collection Fund and Pension Fund	Small business programme generally	500,000
Central Budgets including Collection Fund and Pension Fund	Pay Award 2022-23	2,300,000
Children and Young People	Placements for Looked After Children and Care Leavers	2,000,000
Children and Young People	OFSTED Recovery Plan / Staffing	400,000
Children and Young People	Availability of accommodation- NRPF	300,000
Environment and Sustainable Transport	Vehicle Maintenance	500,000
Environment and Sustainable Transport	Fuel Inflation	350,000
Environment and Sustainable Transport	Parking Income	1,000,000
Environment and Sustainable Transport	Reactive Maintenance	250,000
Environment and Sustainable Transport	Extreme weather	150,000
RMS	RMS trading position	500,000
RMS	RMS trading position	300,000

Directorate	Risk	Potential Annual Impact (where estimated) 2022/23 [£]
Inclusive Economy and Housing	Temporary Accommodation	1,600,000
Inclusive Economy and Housing	Housing Needs Bad Debt Provision	400,000
Inclusive Economy and Housing	Planning Income	400,000
Inclusive Economy and Housing	Victoria Street Decant	1,500,000
Inclusive Economy and Housing	Marlin Price Increase	500,000
Resources	Investment properties Rental Income	1,500,000
oneSource non-shared	Schools PFI	5,000,000
oneSource non-shared	Cyber Attack	27,000,000
Digital	Housing Benefits	500,000
Digital	Housing Benefits	2,500,000
Digital	Council Tax Court Costs	500,000
Digital	Customer Services	245,000
Housing Revenue Account	Fire/Building Safety	£1.75m
Housing Revenue Account	Canning Town PFI Fire Safety Liability	Total risk is likely to be £2m, detailed costings awaited
Housing Revenue Account	Rent Income uplift - Inflationary pressures	Unquantified
Total		**50,195,000**

Newham Place Information - Contents

Better Care Fund (BCF) 2022-23

- BCF plans were submitted to NHSE in September 2022,
- Approval letters are expected from NHSE by 30 November 2022.
- Section 75 variation letters to be completed by 31 December 2022.
- The ICB minimum spend contribution has increased in line with planning guidance by 5.66%
- The BCF contains metrics for admissions avoidance, discharge to the usual place of residence (NHS), care home admissions and reablement (local authority). Additionally, for 2022/23 a demand and capacity template was submitted which includes urgent care response and discharge related services.
- Additional schemes in the ICB (£30m) include payments to ELFT. These services are monitored as part of the overall month end closedown process and are expected to report a breakeven position at year-end.

Newham BCF Summary 2022/23	***£(000)***
Historical Protection	£10,161
CHC/Joint Funding	£2,022
FNC	£842
Equipment	£1,994
Protection of Social Care	£6,180
Care Act	£1,175
Social Prescription	£180
Wheelchair Services	£1,563
COVID IDH	£253
Inequality, Prevention, Transformation	£250
Total	**£24,622**
Improved Better Care Fund	£17,193
LA Capital funding	£2,848
Total LA pooled / non pooled amounts	£4,702
Additional schemes (non-contribution based)	£108,669
Total Transfer & Pooled amount	**£158,034**

Transformation and SDF Funding 2022-23

- The ICB has received system development funds (SDF) that can be identified by place.

- Funding for virtual wards has been allocated to place. The aim of the funding is to prevent avoidable admissions or support early discharge out of hospital, with a national requirement to deliver virtual wards at a place / borough level. The model will be developed across the system partners. The Havering place share of the funding is £893k.
- The majority of the Mental Health (MH), Learning Difficulties and Autism (LDA) SDF is held in the ELFT contract. Therefore, the ICB is expecting full spend against this SDF.

Type of Funding	Programme Category	Newham £'000s
SDF	Ageing Well	1,211
SDF	Virtual Ward	893
SDF	Mental Health	296
SDF	Learning Difficulties and Autism	6,227
Total		8,627

Progress updates to future meetings:

- Update from ELFT on Mental Health and LDA SDF.
- Update from place based partnership on ageing well plans and timescales.

Non Recurrent BCF from 2021-22 - Integrated Discharge Hub

- In 2021/22 additional funds were transferred via a section 75 (s75) agreement to the local authority for an Integrated Discharge Hub (IDH).
- At the end of 2021/22 these funds were underspent. The s75 agreement allowed for them to be carried forward to 2022/23.
- The total IDH fund available is £3,035k.

- As per M07 the table below summarises the associated IDH costs:

Progress update to future meeting:
- ICB information on spend on the discharge pathway and associated equipment costs
- Update on non-recurrent ageing well plans and associated spend.

Newham Place - Integrated Discharge Hub (IDH) Costs as at Month-8 2022/23

No.	Project	Agreed Planned Amount £'000	22/23 Year to Date £'000	22/23 Year to Go £'000	22/23 Forecast £'000	(Overspend) / Underspend £'000	Provider
1	LBN Pathway 1	1,146	809	405	1,214	(68)	LBN
2	LBN Pathway 2	357	247	124	371	(14)	LBN
3	LBN Pathway 3	24	23	12	35	(11)	LBN
4	LBN Other IDH Costs	473	345	173	518	(45)	LBN
5	ICB Pathway 1	139	87	43	130	9	ICB
6	ICB Pathway 3	48	34	17	51	(3)	ICB
7	Integrated Discharge Hub	846	600	300	900	(54)	ELFT
	Total	**3,035**	**2,145**	**1,074**	**3,219**	**(184)**	

Note: The total IDH fund available is £3,035k. The planned figures shown above agianst individual lines have been apportioned based the current forecast spend.

Winter Demand and Capacity Funding 2022-23

- The NEL system was allocated £12,279k for winter demand and capacity funds.
- The Newham share of this is £303k.
- Details of the schemes are shown in the table below.
- The funding will be in place for the period November to March 2023.

Newham

Type of scheme	**Description of the scheme** and which boroughs or trusts it covers.	**Key partners** In the description of the scheme please include which organisation you wish the expenditure to be with i.e.: under s.75 with Local Authorities, contracts with providers or direct CHC expenditure	**Cost of the scheme**
Stepdown Capacity	**Medical capacity** at Step Down Unit to allow weekend admissions.	ELFT - CHS Provider	£302,925.00
Discharge team capacity and 7 day discharge	X **Social workers** to ensure weekend working and to manage increased activity.	London Borough of Newham	
Discharge team capacity and 7 day discharge	**Trusted Assessor** to improve discharges into care homes	London Borough of Newham (LBN)	
Discharge team capacity and 7 day discharge	GP Inreach to pull pathway 0 + 1 patients from the Ward	GP Federation	
Discharge team capacity and 7 day discharge	**Brokerage Officers** @ 2 FTEs	London Borough of Newham (LBN)	

Health Inequalities Funding 2022-23

- Total Health Inequalities funding of £6,570k received by the ICB in 2022/23.
- It was agreed that the majority of funding would be allocated to place to tackle health inequalities through place based partnerships.
- There were 2 pots of funding available to place. Pot A was an equal share and each borough was awarded £500k. Pot B was discretionary and allowed for bids of up to £600k. A panel evaluated the bids and funding was allocated based on those proposals that would make the greatest impact on health inequalities.
- Total funding awarded to Newham was £989k (£500k pot A and £489k pot B). Reporting in future months will be against agreed projects.
- Place based partnerships nominated local authorities to hold and administer the funds, via a formal section 256 (s256).
- Discussions have taken place between the ICB and LBN and some revisions to the original projects/arrangements have been agreed.
- The s256 agreement is now with the council and ICB for signing.
- Projects are due to start from 1 September onwards.
- Updates on spend against the projects will be given when monitoring information becomes available.

22.23 Health Inequalities	
Name of project	Grand Total £000s
Small grants to VCSF	207
Capacity building and training	90
Capacity building and training	163
Community chest	40
Casefinding outreach work	232
Refugees	100
Men's parental peer support	60
SEND capacity	40
Trauma-informed framework	35
Cell Salvage	20
LD information	2
	989

Innovation Funds 2022-23

- Total Innovation funding awarded to Newham was £7.2m. The table below gives a breakdown of the agreed investment and the remaining balance of the overall funding pot.
- Place based partnerships nominated local authorities to hold and administer the funds, via a formal Section 256.
- The Section 256 agreement has been signed by the council and the ICB.
- Projects have already started.
- Updates on spend against the projects will be provided at future board meetings.

No.	Project	Agreed Planned Amount £Ms	22/23 Forecast £'Ms	23/24 Forecast £'Ms	22/23 + 23/24 Forecast £'Ms	(Overspend) / Underspend	Provider
1	SEND (therapies)	£4.1	£2.1	£2.1	£4.1	£0.0	ELFT
2	SEND (therapy waiting times backlog)	£0.4	£0.4		£0.4	£0.0	ELFT
3	CYP investment (including safeguarding)	£1.1	£0.6	£0.6	£1.1	£0.0	Barts / ELFT
4	Autism diagnostic service	£0.7	£0.4	£0.4	£0.7	£0.0	ELFT
5	Frailty (pilot and testing)	£0.1	£0.1		£0.1	£0.0	ELFT
6	Community Equipment (Enabled Living)	£0.8	£0.4	£0.4	£0.8	£0.0	LBN
7	Pulmonary Rehabilitation	£0.0	£0.3	£0.3	£0.5	-£0.5	*Innovations scheme funded via alternate funding stream*
	Total	**£7.20**	**£4.10**	**£3.60**	**£7.70**	**-£0.50**	