# Redbridge Place based Partnership Board and Sub Committee

Thursday 20 April 2023, 1415 – 1430 **by Teams at this link**

**Chair: Adrian Loades, Place Partnership Lead (also Corporate Director of People, London Borough of Redbridge)**

| **Redbridge Place based Partnership Sub Committee business in public** | | | | | |
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| **7.** | **Place Sub-Committee Terms of Reference & Mutual Accountability Framework** | 1415 (10 mins) | Charlotte Pomery | Papers<br><br>*Pages 2-47* | Discuss/ Approve |
| **8.** | **Any Other Business:**<br>· Forward Plan | 1425 (5 mins) | Chair | Verbal | Discuss |
| **Date of next meeting:**<br><br>Thursday 18 May 2023 Partnership Board meeting by Teams | | | | | |

# Redbridge Place based Partnership Sub-Committee

2 March 2023

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| **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** | |
| **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.<br><br>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:<br>(a) more formal integrated ways of working involving the broad range of partners across the ICS; and<br>(b) the lawful and efficient delegation of functions based on the principle of subsidiarity.<br><br>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.'<br><br>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 |

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| | 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.<br><br>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.<br><br>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:<br>· to improve outcomes in population health and healthcare;<br>· to tackle inequalities in outcomes, experience and access;<br>· to enhance productivity and value for money; and<br>· 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 |

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| | care system is critical to our overall success because places are:<br>· where the NHS, local authorities, and the voluntary and community sector integrate delivery, supporting seamless and joined up care;<br>· where we will most effectively tackle many health inequalities through prevention, early intervention, and community development, including at neighbourhood level;<br>· where diverse engagement networks generate rich insight into residents' views;<br>· where we can build detailed understandings of need and assets on a very local basis and respond with appropriate support; and<br>· where the NHS and local authorities as a partnership are held democratically accountable.<br>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.<br>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. |

# REDBRIDGE

# 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 ('**PBP**') to enable the improvement of health, wellbeing and equity in the Redbridge area ('**Place**'):

    (a) Barts Health NHS Trust ('**Barts**')

    (b) Barking, Havering and Redbridge University Hospitals Health NHS Trust ('**BHRUT**')

    (c) North East London NHS Foundation Trust ('**NELFT**')

    (d) London Borough of Redbridge ('**LBR**')

    (e) HealthBridge Direct

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

    (g) Primary Care Networks ('**PCN**s')

    (h) Healthwatch Redbridge

    (i) Redbridge CVS

    (j) Care providers

    (k) Training Hub

    (l) Local Pharmaceutical Committee ('**LPC**')

    (m) Local Medical Committee ('**LMC**')

    (n) Local Dental Committee ('**LDC**')

    (o) Local Optical Committee ('**LOC**')

    (p) Partnership of East London Cooperatives ('**PELC**')

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

3. These terms of reference for the PBP incorporate:

    (a) As Section 1, terms of reference for the Redbridge 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 Redbridge ICB 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. As far as possible, the partner organisations will aim to exercise their relevant statutory functions within the PBP governance structure, including as part of meetings of the Partnership Board. This will be enabled (i) through delegations by the partner organisations to specific individuals; or (ii) through specific committees/sub-committees established by the partner organisations meeting as part of, or in parallel with, the Partnership Board.

5. 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.

6. 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 and hold meetings in tandem.

7. Where a member of the Partnership Board is not also a member of a structure described in Section 2, it is expected that the Partnership Board member will receive a standing invitation to meetings of those structures (which may be held in tandem with Partnership Board meetings) and, where appropriate, will be permitted to contribute to discussions at such meetings to help inform decision-making. This is, however, subject to any specific legal restrictions applying to the functions or partner organisations and subject to conflict of interest management.

8. 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 Redbridge Partnership Board

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| **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.<br><br>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 LBR. |
| **Vision and purpose** | 4. Our vision is to bring together partners across Place as the Partnership Board to focus relentlessly on improving the outcomes for the people of Redbridge and seek always to make a positive difference to people's lives. Together, we will build on what we have already achieved and use our combined resources to create person-centred, responsive care to build services around the needs of our communities within Redbridge. We will have a strong focus on prevention, addressing inequalities and the wider determinants of health.<br><br>5. The Partnership Board exists to:<br><br>(a) **Achieve Success Through Partnership**<br><br>· We will constantly challenge ourselves to work collaboratively and add value<br><br>· We will be prepared to have difficult conversations when required to improve outcomes for local people<br><br>· We will hold ourselves accountable for our impact on our partners<br><br>(b) **Ensure System Wide Approaches**<br><br>· Improving the connectivity of services and ensure that the contribution of everyone is recognised<br><br>· Developing Multi-Disciplinary Team approach across Redbridge |

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| | (c) **Improve Engagement**<br>· Involving local people in the design and delivery of services to meet the needs of the communities within Redbridge<br>(d) **Deliver value-based services**<br>· Shared goals and objectives across partners<br>· Population-based services supported by evidence. | |
| **Ways of working** | **How we will Work** | **What this means to us** |
| | **Focus on the outcomes that matter to local people** | We will measure our success by measuring those outcomes that matter to people, not just on what can or must be measured. |
| | **Holding ourselves and each other accountable** | We are committed to working together, we recognise that systems not people are the problem and we will support each other – including having difficult conversations when necessary. |
| | **Delivering change 'with' local people rather than 'for' or 'to' them** | Placed-based partnership has no meaning if we continue with traditional top-down planning and change. Our long-term priority is to develop the tools, means and processes to fully engage local people and communities in the decisions that affect them about how local services are delivered. |
| | **Commitment not compliance** | Commitment comes because people feel engaged and listened to. Compliance happens when people feel they are being told what to do. People will feel committed because they will feel they, and their voice, matters. |
| | **System thinking rather than silo-working** | It is not the effectiveness of the parts that matter, it is how those parts inter-connect and work together. Our approach will be to encourage partners and colleagues to understand the inter-connectiveness of the system and how we all contribute to improving the outcomes for local people and communities. Our focus will be on supporting MDT approaches across Place. |
| | **Moving away from the medicalised status quo** | The research has been done and the evidence is clear, yet on a day-to-day basis, services continue to operate within the medicalised status quo. The aim of the Partnership is to implement realistic, practical changes in the way services are delivered that move us away from |

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| | | medicalized models that fail to recognise individual needs. |
| | **Creating excitement and enthusiasm** | The partnership will tap into the passion, enthusiasm and commitment of our teams and local people. |

5.

**Role of the Partnership Board**

6. The Partnership Board provides a forum for the members set out below to:

   (a) Take responsibility for the delivery of the Partnership's priorities;

   (b) Support innovation and engagement through task and finish or design groups;

   (c) Oversee and monitor design of task and finish groups who will be responsible for the delivery of projects set out in the Roadmap;

   (d) Ensure systems intelligence data is available to inform discussions on delivery of projects and identify new projects which may need to be delivered;

   (e) Stay abreast of local and national developments relating to integration;

   (f) Observe and be guided by the values and vision of the Partnership;

   (g) Take decisions on behalf of their organisation in relation to any jointly funded programme allocation including PMO matters.

7. 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 Redbridge Health and Wellbeing board ('**HWB**'), together with the needs assessment for the area;

- the Place Mutual Accountability Framework. [1]

(b) To develop the Place Based Partnership Plan for Redbridge ('**PBP Plan'**), known as the *Roadmap*, 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 Redbridge.

(c) As part of the development of the PBP 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 PBP 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 ('**SQG**') 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.

[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 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.

- timely insight into quality concerns/issues that need to be addressed, responded to and escalated within each partner organisation through appropriate governance structures or individuals, or to the SQG.
- 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 transparency.

(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**

8. 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.

9. However, ordinarily, in accordance with their specific governance arrangements set out in Section 2, a decision made by a committee or other structure (for example a decision taken by the Place ICB Sub-Committee on behalf of the ICB) will be with Partnership Board members in attendance and, where appropriate, contributing to the discussion to inform the statutory decision-making process. This is, however, subject to any specific legal restrictions applying to the

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| | functions of a partner organisation and subject to conflict of interest management. |
| **Making recommendations** | 10. 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.<br><br>11. 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.<br><br>12. 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** | 13. 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.<br><br>14. 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.<br><br>*Collaboration with the HWB*<br><br>15. The Partnership Board will work in close partnership with the HWB and shall ensure that the PBP 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.<br><br>*Safeguarding collaboration*<br><br>16. The Partnership Board will also work in close partnership with the Redbridge Safeguarding Children Partnership and the Safeguarding Adults Board for Redbridge. |
| **Chairing arrangements** | 17. The Chair of the Partnership Board will be the Corporate Director of People, LBR, who is also the Place Partnership Lead. |

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| | 18. The Deputy Chair of the Partnership Board will be the Clinical Care Director for Redbridge.<br><br>19. 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** | 20. There will be a total of 29 members of the Partnership Board, as follows:<br><br>*Place:*<br><br>(a) Place Partnership Lead (also the Corporate Director of People, LBR)<br><br>(b) Delivery Director for Redbridge<br><br>(c) Clinical Care Director for Redbridge<br><br>*ICB:*<br><br>(d) Director of Finance or their nominated representative<br><br>(e) Director of Nursing/Quality or their nominated representative<br><br>*London Borough of Redbridge:*<br><br>(f) Director of Public Health<br><br>(g) Cabinet Member for Adult Social Care and Health<br><br>*NHS Trusts/Foundation Trusts:*<br><br>(h) Director of NELFT<br><br>(i) Director of BHRUT<br><br>(j) Director of Barts<br><br>*Primary Care:*<br><br>(k) Place Based Partnership Primary Care Development Clinical Lead<br><br>(l) Chair, HealthBridge Direct<br><br>(m) Loxford Clinical Director<br><br>(n) Seven Kings Clinical Director<br><br>(o) Fairlop Joint Clinical Directors<br><br>(p) Cranbrook Joint Clinical Directors |

(q) Wanstead & Woodford Clinical Director

(r) New Cross Alliance Joint Clinical Directors

*Voluntary sector:*

(s) Representative, of Redbridge CVS

(t) Representative, of Redbridge CVS

*Healthwatch:*

(u) Representative, Healthwatch Redbridge

*Others:*

(v) Care Providers representative

(w) Community representatives

(x) Training Hub representative

(y) LDC Representative

(z) LMC representative

(aa) LPC representative

(bb) LOC representative

(cc) PELC representative

21. 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**

22. 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**

23. 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*

24. 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.

25. 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.

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

*Scheduling meetings*

27. The Partnership Board will normally meet monthly, for a maximum of 2 hours.

28. On a bi-monthly basis, subject to a minimum of four occasions each year, the Partnership Board will hold its meetings in tandem with the Place ICB Sub-Committee. [2]

29. The expectation for such meetings to be held in tandem will not preclude the Partnership Board from holding its own more regular or additional meetings.

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

*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 occasion 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

~~[2] In the first financial year of operation the Place ICB Sub-Committee is only expected to meet on three occasions.~~

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| | constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes.<br><br>*Admission of the public*<br><br>34. Where the Partnership Board meets jointly with the Place ICB Sub-Committee in accordance with paragraph 27, its meetings shall be held in accordance with the Place ICB Sub-Committee's terms of reference in Section 2. Otherwise, whether a meeting of the Partnership Board is to be held in public or private is a matter for the Chair.<br><br>*Recordings of meetings ~~and publication~~*<br><br>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.<br><br>*Minutes*<br><br>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.<br><br>37. Where it would promote efficient administration, meeting minutes, action logs and any work plan, may be combined with those of the Place ICB Sub-Committee.<br><br>*Governance support*<br><br>38. Governance support to the Partnership Board will be provided by the ICB's governance team.<br><br>*Confidential information*<br><br>39. 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** | 40. The Partnership Board is the primary forum within the Redbridge 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.<br><br>41. 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 |

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| | 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.<br><br>42. 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.<br><br>43. In the event that the Partnership Board is unable to agree a consensus position on a matter it is considering, this will not prevent any or all of the statutory committees/sub-committees in Section 2 taking any applicable decisions they are required to take. To the extent permitted by their individual terms of reference, statutory committees may utilise voting on matters they are required to take decisions on. |
| **Conflicts of Interest** | 44. 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** | 45. 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.<br><br>46. Members of the Partnership Board shall disseminate information back to their respective organisations as appropriate, and feedback to the group as needed.<br><br>47. 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.<br><br>48. Given its purposes at paragraph 7(e) above, the Partnership Board will regularly report upon, and comply with any request of the SQG for information or updates on, matters relating to quality which effect the ICS and bear on the SQG's remit. |
| **Monitoring Effectiveness and Compliance with Terms of Reference** | 49. 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. |

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| | 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 Redbridge Sub-Committee of the North East London Integrated Care Board

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| **Status of the Sub-Committee** | 1. The Redbridge 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.<br><br>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.<br><br>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.<br><br>4. These terms of reference should be read as part of the suite of terms of reference for the Redbridge Place-Based Partnership ('**PBP**'), including the terms of reference for the Redbridge 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:<br><br>(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 PBP;<br><br>(b) Support the development of collaborative arrangements at Place, in particular the development of the PBP.<br><br>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.<br><br>8. The Place ICB Sub-Committee, through its members, is authorised by the ICB to take decisions in relation to the Delegated Functions.<br><br>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 |

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| | Accountability Framework, which may be updated by the Board taking into account the views of the PH&I Committee.<br><br>10. The Delegated Functions shall be exercised with particular regard to the Place objectives and priorities, described in the plan for Place ('**the PBP Plan'**), which has been agreed with the PH&I Committee and the partner organisations represented on the Partnership Board. A summary of the PBP's priorities and objectives can be found here.<br><br>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:<br><br>(a) The Joint Forward Plan;<br><br>(b) The Joint Capital Resource Use Plan;<br><br>(c) The Integrated Care Strategy prepared by the NEL Integrated Care Partnership;<br><br>(d) The HWB's joint local health and wellbeing strategy with the HWB's needs assessment for the area;<br><br>~~(d)~~(e) The Place Mutual Accountability Framework and the NHS North East London Financial Strategy and developing ICS Financial Framework;<br><br>~~(e)~~(f) The PBP Plan.<br><br>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.<br><br>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:<br><br>(a) Improve outcomes in population health and healthcare;<br><br>(b) Tackle inequalities in outcomes, experience and access;<br><br>(c) Enhance productivity and value for money;<br><br>(d) Help the NHS support broader social and economic development.<br><br>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 decisions are informed by, the guidance, policies and procedures of the ICB or which apply to the ICB. |

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| **Delegated Functions** | 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 2006 Act and listed in the Constitution. 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.<br><br>*Collaboratives*<br><br>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 PBP, the Place ICB Sub-Committee will, as appropriate, work with the following provider collaborative governance structures within the area of the ICS:<br><br>(a) The North East London Mental Health, Learning Disability & Autism Collaborative;<br><br>(b) The Combined Primary Care Provider Collaborative;<br><br>(c) The North East London Acute Provider Collaborative;<br><br>(d) The North East London Community Collaborative.<br><br>~~(d)~~(e) The evolving Voluntary, Community and Social Enterprise Sector Alliance/Collaborative.<br><br>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.<br><br>*Health & Wellbeing Board and Safeguarding*<br><br>20. The Place ICB Sub-Committee will also work in close partnership with:<br><br>(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<br><br>(b) The Safeguarding Adults Board for the Place established by the local authority under section 43 of the Care Act 2014; and<br><br>(c) The Safeguarding Children's Partnership established by the local authority, ICB and Chief Officer of Police, under section 16E of the Children Act ~~2014~~2004. |

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| | *Establishing working groups*<br><br>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 PBP. 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 Corporate Director of People, London Borough of Redbridge. The Chair is appointed on account of their specific knowledge, skills and experiences making them suitable to chair the Sub-Committee.<br><br>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.<br><br>24. The Deputy Chair of the Place ICB Sub-Committee is the Clinical Care Director for Redbridge.<br><br>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.<br><br>26. The Corporate Director of People, London Borough of Redbridge is also the Place Partnership Lead. |
| **Membership** | 27. 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.<br><br>28. 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 2006 Act by the Health and Care Act 2022.<br><br>29. The membership of the Place ICB Sub-Committee includes members drawn from the following partner organisations which operate at Place:<br><br>(a) The ICB<br><br>(b) Barts<br><br>(c) BHRUT<br><br>(d) NELFT<br><br>(e) LBR<br><br>(f) HealthBridge Direct and PCNs |

(g) Healthwatch Redbridge

(h) Redbridge CVS

30. There will be a total of 14 members of the Place ICB Sub-Committee, as follows:

*Place:*

(a) Place Partnership Lead (also the Corporate Director of People, London Borough of Redbridge)

(b) Delivery Director for Redbridge

(c) Clinical Care Director for Redbridge

*ICB:*

(d) Director of Finance or their nominated representative

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

*London Borough of Redbridge:*

(f) Director of Public Health

(g) Cabinet Member for Adult Social Care and Health

*NHS Trusts/Foundation Trusts:*

(h) Director of NELFT

(i) Director of BHRUT

(j) Director of Barts

*Primary Care:*

(k) Place Based Partnership Primary Care Development Clinical Lead

(l) One other primary care representative.[3]

*Voluntary sector:*

(m) One representative of Redbridge CVS, who is a member of the Partnerships.

*Healthwatch:*

[3] This role will be fulfilled by one of the Clinical Directors on the Partnership Board or the Chair of HealthBridge Direct. It shall rotate through each of the primary care representatives every six months as determined by the Place Partnership Lead.

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| | (n) The representative of Healthwatch Redbridge, who is a member of the Partnerships.<br><br>31. 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.<br><br>32. When determining the membership of the Sub-Committee, active consideration will be made to diversity and equality. |
| **Participants** | 33. 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.<br><br>34. Meetings of the Sub-Committee may also be attended by the following for all or part of a meeting as and when appropriate:<br><br>(a) Any members of the Partnership Board (i.e. in Section 1)<br><br>35. 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** | 36. 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.<br><br>~~36.~~37. 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** | ~~37.~~38. 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:<br><br>*Scheduling meetings*<br><br>~~38.~~39. 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.[4]

~~39.~~40. The Place ICB Sub-Committee will usually hold its meetings together with the Partnership Board, as part of an aligned meeting of the PBP. Although the Place ICB Sub-Committee may meet on its own at the discretion of its Chair, it is expected that such circumstances would be rare.

~~40.~~41. The Place ICB Sub-Committee acknowledges that the Partnership Board may convene its own more regular meetings, for instance where agenda items do not require a statutory decision of the Place ICB Sub-Committee.

~~41.~~42. 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*

~~42.~~43. 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:

(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.

~~43.~~44. 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.

~~44.~~45. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

*Voting*

~~45.~~46. 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*

~~46.~~47. A minimum of seven clear working days' notice is required. Notice of all meetings shall comprise venue, time and date of the meeting, together

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

with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

~~47.~~48. On occasion 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*

~~48.~~49. 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*

~~49.~~50. 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.

~~50.~~51. 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.

~~51.~~52. 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.

~~52.~~53. 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.

~~53.~~54. There shall be a section on the agenda for public questions to the Sub-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~~*

~~54.~~55. 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*

~~55.~~56. Where confidential information is presented to the Place ICB Sub-Committee, all those who are present will ensure that they treat that

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| | information appropriately in light of any confidentiality requirements and information governance principles.<br><br>*Meeting Minutes*<br><br>~~56.~~57. 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.<br><br>~~57.~~58. Where it would promote efficient administration, meeting minutes and/or action logs may be combined with those of the Partnership Board.<br><br>*Legal or professional advice*<br><br>~~58.~~59. 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.<br><br>*Governance support*<br><br>~~59.~~60. Governance support to the Place ICB Sub-Committee will be provided by the ICB's governance team.<br><br>*Conflicts of Interest*<br><br>~~60.~~61. 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** | ~~61.~~62. Members will be expected to behave and conduct business in accordance with:<br><br>(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.<br><br>(b) The NHS Constitution;<br><br>(c) The Nolan Principles.<br><br>~~62.~~63. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make. |
| **Disputes** | ~~63.~~64. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the Place ICB Sub-Committee |

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| | in its capacity as a decision-making body within the ICB's governance structure, including uncertainty about whether the matter relates to:<br><br>(a) a matter for wider determination within the ICS; or<br><br>(b) determination by another placed-based committee of the ICB or other forum, such as a provider collaborative,<br><br>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** | ~~64.~~65. 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.<br><br>~~65.~~66. 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:<br><br>(a) The Chair of the Place ICB Sub-Committee, at his or her discretion, may determine that such a referral should be made.<br><br>(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.<br><br>~~66.~~67. Where a matter is referred to the PH&I Committee under paragraph ~~64~~65, 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.<br><br>~~67.~~68. In addition to the Place ICB Sub-Committee's ability to refer a matter to the PH&I Committee as set out in paragraph ~~64~~65:<br><br>(a) The PH&I Committee, or its Chair and Deputy Chair (acting together), may determine that any decision falling with paragraph ~~64~~65 should be referred to the PH&I Committee for determination; or<br><br>(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** | ~~68.~~69. The Place ICB Sub-Committee shall be directly accountable to the PH&I Committee of the ICB, and ultimately the Board of the ICB.<br><br>~~69.~~70. The Place ICB Sub-Committee will report to: |

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| | (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.<br><br>And will report matters of relevance to the following:<br><br>(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.<br><br>(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.<br><br>~~70.~~71. 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.<br><br>*Shared learning and raising concerns*<br><br>~~71.~~72. 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** | ~~72.~~73. The Place ICB Sub-Committee will review its effectiveness at least annually.<br><br>~~73.~~74. 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:** 15 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, 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 PBP Plan including the Place objectives and priorities and a Place outcomes framework.

   *The PBP Plan shall be developed by drawing on data and intelligence, and in coproduction with service users and residents of Redbridge. 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 PBP Plan, and summarised here, and an associated outcomes framework developed by the PBP.*

   *The PBP 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 the 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 PBP 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 PBP 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 ICB's SFIs. 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 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, KPIs 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.

~~11.~~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 is adequate governance and arrangements in Place that is 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 ('SQG') 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 |
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| **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.<br>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.<br>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.<br>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:<br>· relationships with local authorities, local providers, community groups, and residents;<br>· participation and co-production with residents;<br>· the insight to understand and tackle local population health and inequalities;<br>· supporting system financial sustainability; and<br>· building integrated models of insight, planning, and delivery.<br>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.<br>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. |

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| **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.<br>Ø *How NHS North East London will help*<br>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.<br>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.<br>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.<br>Ø *How NHS North East London will help*<br>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.<br>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 |

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| | 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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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 |

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| | dementia-friendly policies which could be met by the all-age approach supported by place partnerships.<br>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.<br>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.<br>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.<br>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.<br>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:<br>· ensuring GP registration and primary care support to this cohort;<br>· improving access to secondary and tertiary care as appropriate;<br>· recognising the needs of the homeless population for all levels of support, care, and treatment across mental and physical health; and<br>· 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. |

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| **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:<br>· ensuring GP registration and primary care support to this cohort;<br>· improving access to secondary and tertiary care as appropriate;<br>· recognising the needs of the asylum seekers for all levels of support, care, and treatment across mental and physical health; and<br>· 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 |
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| **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<br>· 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<br>· 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<br>· 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<br>· 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 |

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| | · 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<br>· 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<br>· 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<br>· 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<br>· 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<br>· 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<br>· This will be in the form of a defined data set agreed between NHS NEL and the place partnerships<br>· 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.<br>· NHS North East London will provide capacity for bespoke local analysis commissioned and directed by place partnerships |

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