North East London
Integrated Care Board

NHS North East London Integrated Care Board

31 May 2023, 1.30pm – 3.45pm; Havering Town Hall, Main Road, Romford, RM1 3BD

Agenda

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	1.30	Chair		Note
1.1.	Declaration of conflicts of interest			Attached	Note
1.2.	Minutes of the meeting held on 29 March 2023			Attached	Approve
1.3.	Matters arising			Verbal	Note
1.4.	Actions log			Attached	Note
2.0	**Resident story**	1.35		Verbal	Discuss/ note
3.0	**Chair and chief executive reports**				
3.1.	Chair's report	1.55	Chair	Attached	Note
3.2.	Chief executive officer's report	2.00	ZE	Attached	Note
4.0	**Strategy**				
4.1.	Operating plan and 2023/24 ICB Budget	2.05	HB	Attached	Approve
4.2.	Making north east London a Living Wage system	2.15	FO	Attached	Endorse and note
5.0	**Quality**				
5.1.	Deep dive: mental health and wellbeing in north east London	2.25	PG/PC	Attached	Note
6.0	**Finance and performance**				
6.1.	Month 12 2022-23 finance overview and draft financial statement update	2.45	HB	Attached	Note
6.2.	Performance report – February 2023 period	2.55	HB	Attached	Note
7.0	**Governance**				
7.1.	Governance handbook amendments	3.05	CPo	Attached	Approve
7.2.	Board Assurance framework	3.15	CPo	Attached	Note
7.3.	Committee exception reports for information: • Audit and Risk Committee exception report • Workforce and Remuneration Committee exception report • Quality, Safety and Improvement committee exception report • Finance, Performance and Investment committee exception report • Population Health and Integration committee exception report	3.25	Chair	Attached	Note

	Item	Time	Lead	Attached/ verbal	Action required
8.0	**Board forward plan**	3.30	Chair	Attached	Discuss
9.0	**Questions from the public**	3.35	Chair	Verbal	Discuss
10.0	**Any other business and close**	3.45	Chair	Verbal	Discuss
Date of next meeting: 23 June 2023 1.30pm – 2.30pm – to be held via Teams					

Purpose, priorities, aims and our decision-making principles

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

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

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

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

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

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

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

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

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

The four aims of our integrated care system

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

Our decision-making principles

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

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

NHS
North East London

North East London Integrated Care Board Register of Interests

- Declared Interests as at 23/05/2023

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Andrew Blake-Herbert	Chief Executive; London Borough of Havering	Havering ICB Sub-committee Havering Partnership Board ICB Board ICB Workforce & Remuneration Committee ICS Executive Committee	Financial Interest	London Borough of Havering	Employed as Chief Executive	2021-05-01		Declarations to be made at the beginning of meetings
Caroline Rouse	Member of IC Board (VCS rep)	ICB Board ICP Committee	Financial interest	Compost London CIC	Director	2018-01-05		
Cha Patel	ICB Board Non-Executive Member	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee	Financial Interest	Eastlight Homes	Member of Board; Chair of Audit and Risk; member of Finance and Performance Committee	2022-12-12		
			Financial Interest	Community Health Partnerships	Member of Board; member of Audit Committee; Chair of Finance, Investment and Systems Committee	2022-12-12		
			Financial Interest	Igloo Consultants Limited	Director of family owned consultancy business	2022-12-12		
Diane Herbert	Non-Executive Member	ICB Board ICB Workforce & Remuneration Committee ICB Quality, Safety & Improvement Committee	Non-Financial Professional Interest	Hertfordshire Partnership University Foundation Trust (HPFT)	Non executive director	2019-05-19		
Diane Jones	Chief Nurse	ICB Board Clinical Advisory Group ICB Quality, Safety & Improvement Committee ICS Executive Committee Primary care contracts sub-committee	Non-Financial Professional Interest	Royal College of Nursing (RCN)	Professional membership	2020-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of Midwives (RCM)	Professional membership	1994-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Nursing & Midwifery Council (NMC)	Professional membership	1992-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Clinical Senate	Member	2017-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Homerton Hospital	Midwife (honorary contract)	2015-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Group B Strep Support (GBSS)	Director and Trustee	2020-01-01		Declarations to be made at the beginning of meetings

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Dr Mark Rickets	ICB Primary Care Partner Member	ICB Board ICB Finance, Performance & Investment Committee ICB Workforce & Remuneration Committee NEM Remuneration Committee Primary Care Collaborative sub-committee	Financial Interest	Nightingale Practice (CCG member practice)	Salaried GP	2022-02-02		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	GP Confederation	Nightingale Practice is a member	2022-02-02		Declarations to be made at the beginning of meetings
			Indirect Interest	Health Systems Innovation Lab, School Health and Social Care, London South Bank University	Wife is a Visiting Fellow	2022-02-02		Declarations to be made at the beginning of meetings
			Financial Interest	Homerton University Hospital NHS Foundation Trust	Non-executive Director	2022-02-02		Declarations to be made at the beginning of meetings
			Indirect Interest	Point of Care Foundation	Wife is an Associate with the Point of Care Foundation whose work includes being a mentor for NEL ICS Schwartz Rounds	2022-03-01		Declarations to be made at the beginning of meetings
Dr Paul Francis Gilluley	Chief Medical Officer	ICB Board Clinical Advisory Group ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Primary care contracts sub-committee	Non-Financial Professional Interest	British Medical Association	I am a member of the organisation.	2022-07-01		
			Non-Financial Professional Interest	Royal College of Psychiatrists	Fellow of the College	2022-07-01		
			Non-Financial Professional Interest	Medical Defence Union	Member	2022-07-01		
			Non-Financial Professional Interest	General Medical Council	Member	2022-07-01		
			Non-Financial Personal Interest	Stonewall	Member	2022-07-01		
Henry Black	Chief Finance and Performance Officer	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee Primary Care Collaborative sub-committee	Indirect Interest	BHRUT	Wife is Assistant Director of Finance	2018-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Tower Hamlets GP Care Group	Daughter is Social Prescriber	2020-01-01		Declarations to be made at the beginning of meetings
Imelda Redmond	Non-Executive Member	ICB Audit and Risk Committee ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee	Non-Financial Professional Interest	Health Devolution Commission	Co-Chair	2023-01-07		

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Dr Jagan John	Primary Care ICB Board representative	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee Primary Care Collaborative sub-committee	Financial Interest	Aurora Medcare (previously known as King Edward Medical Group)	GP Partner	2020-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Parkview Medical Centre	GP Partner	2020-05-01		Declarations to be made at the beginning of meetings
			Financial Interest	Together First Limited (GP Federation)	Practice is a shareholder	2014-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Harley Fitzrovia Health Limited	Director and Shareholder	2018-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Diagnostics 4u (previously Monifieth Ltd)	Director and Shareholder	2020-10-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Aurora Medcare (previously known as King Edward Medical Group)	Other GPs are family members	2020-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	New West Primary Care Network	Brother / GP Partner is the Clinical Director	2020-11-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Transformation partners in health and care / NHS England -London Region	Personalised Care Clinical Director	2017-05-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	North East London Foundation Trust – Barking and Dagenham Community Cardiology Service	GPWSI in cardiology	2011-08-01		Declarations to be made at the beginning of meetings
			Financial Interest	Buxton Medica	GP partner is director and practice is share holder	2021-10-31		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barking & Dagenham, Havering and Redbridge University Hospitals Trust	Associate Medical Director for Primary Care in BHRUT	2022-09-01		Declarations to be made at the beginning of meetings
Johanna Moss	Chief strategy and transformation officer	ICB Board ICB Population, Health & Integration Committee ICP Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee Primary Care Collaborative sub-committee	Non-Financial Professional Interest	UCL Global Business School for Health	Health Executive in Residence	2022-09-01		

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Marie Gabriel	ICB and ICP Chair	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICB Workforce & Remuneration Committee ICP Committee NEM Remuneration Committee	Non-Financial Personal Interest	West Ham United Foundation Trust	Trustee	2020-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	East London Business Alliance	Trustee	2020-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Race and Health Observatory	Chair of the RHO	2020-07-23		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Member of the labour party	Member of the labour party	2020-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Confederation	Trustee Associated with my Chair role with the RHO	2020-07-23		Declarations to be made at the beginning of meetings
			Financial Interest	Local Government Association	Peer Reviewer	2021-12-16		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	UKHSA	Associate NED	2022-04-25		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Institute of Public Policy Research (IPPR)	Commissioner on the IPPR Health and Prosperity Commission	2022-03-13		Declarations to be made at the beginning of meetings
Marie Price	Director of Corporate Affairs	ICB Audit and Risk Committee ICB Board ICP Committee	Indirect Interest	Greater London Authority	Partner works as NE London region regeneration lead	2017-01-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Lower Clapton GP Practice, Hackney	Registered as a patient at a GP practice in NEL. Lower Clapton GP Practice, Hackney	2008-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Cadence Partners	Close friends with managing partner and head of operations. Cadence Partners is an executive search firm.	2018-12-03		Declarations to be made at the beginning of meetings
			Indirect Interest	Hackney Council	Close friend with Strategic Director Engagement, Culture and OD (also responsible for communications)	2020-01-01		Declarations to be made at the beginning of meetings

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Paul Calaminus	Chief Executive	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICB Board ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee	Non-Financial Professional Interest	East London NHS Foundation Trust	Chief Executive	2021-04-30		Declarations to be made at the beginning of meetings
			Indirect Interest	Department of Health	Partner is employed by Department of Health	2021-04-30		
Philip Glanville	Local authority rep on ICB Board	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICB Board ICB Finance, Performance & Investment Committee	Financial Interest	London Borough of Hackney	Mayor of Hackney	2016-09-19		
			Financial Interest	London Councils	Chair of Transport & Environment Committee	2020-10-01		
			Financial Interest	Local Government Association (LGA)	Member of LGA Environment, Economy, Housing & Transport Board	2018-08-01		
			Non-Financial Professional Interest	London Legacy Development Corporation (LLDC)	Non-Executive Director of London Legacy Development Corporation (LLDC) appointed by Hackney Council and the Mayor of London	2016-09-19		
			Non-Financial Professional Interest	London Office of Technology and Innovation	London Councils Digital Champion and lead for London Office of Technology and Innovation appointed by London Councils and the Mayor of London	2018-10-01		
			Non-Financial Professional Interest	Central London Forward	Board Member	2016-09-19		
			Non-Financial Professional Interest	Growth Borough Partnership	Board Member	2021-11-17		
			Non-Financial Professional Interest	Greater London Authority (GLA)	Co-Chair of Green New Deal Expert Advisory Panel	2021-03-01		
			Non-Financial Professional Interest	London Councils	Member of London Councils Ltd and London Councils Leaders' Committee	2016-09-19		
			Non-Financial Professional Interest	London Councils	Digital Champion / LOTI Lead	2020-10-01		
			Non-Financial Personal Interest	East London Foundation Trust	Resident Member	2019-08-01		
			Non-Financial Personal Interest	Unison	Union Member	2021-11-01		
			Non-Financial Personal Interest	Unite the Union	Member	2005-05-01		

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Zina Etheridge	Chief Executive Officer of the Integrated Care Board for north east London	ICB Audit and Risk Committee ICB Board ICB Population, Health & Integration Committee ICB Workforce & Remuneration Committee ICP Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee	Indirect Interest	Royal Berkshire NHS Foundation Trust	Brother is employed as Head of Acute Medicine at Royal Berkshire hospital	2022-03-17		Declarations to be made at the beginning of meetings

- Nil Interests Declared as of 23/05/2023

Name	Position/Relationship with ICB	Committees	Declared Interest
Francesca Okosi	Chief People and Culture Officer	ICB Board ICB Workforce & Remuneration Committee ICS Executive Committee NEM Remuneration Committee	Indicated No Conflicts To Declare.
Charlotte Pomery	Chief Participation and Place Officer	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Havering ICB Sub-committee Havering Partnership Board ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Newham Health and Care Partnership Newham ICB Sub-committee Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Partnership Board Waltham Forest ICB Sub-committee Waltham Forest Partnership Board	Indicated No Conflicts To Declare.
Maureen Worby	Local authority rep on ICB Board	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee	Indicated No Conflicts To Declare.
Shane Degaris	ICB member	ICB Board ICS Executive Committee	Indicated No Conflicts To Declare.
Manisha Modhvadia	Healthwatch	ICB Board ICP Committee	In progress

NHS
North East London
Integrated Care Board

Minutes of the NHS North East London ICB board

29 March 2023, 1.30pm – 4.00pm, Committee room 4, Guildhall, City of London

Members:	
Diane Herbert (DH) - Chairing	Non-executive member, NHS North East London
Marie Gabriel (MG)	Chair, NHS North East London and North East London Health and Care Partnership *via MS Teams*
Zina Etheridge (ZE)	Chief executive officer, NHS North East London
Paul Calaminus (PC)	NHS trust partner member
Cllr Maureen Worby (MW)	Local authority partner member *via MS Teams*
Mayor Philip Glanville (PGl)	Local authority partner member
Henry Black (HB)	Chief finance and performance officer, NHS North East London
Paul Gilluley (PGi)	Chief medical officer, NHS North East London
Dr Jagan John (JJ)	Primary care partner member
Dr Mark Rickets (MR)	Primary care partner member *via MS Teams*
Imelda Redmond (IR)	Non-executive member, NHS North East London
Cha Patel (CPa)	Non-executive member, NHS North East London
Attendees:	
Manisha Modhvadia (MM)	Healthwatch participant
Charlotte Pomery (CPo)	Chief participation and place officer, NHS North East London
Francesca Okosi (FO)	Chief people and culture officer, NHS North East London
Johanna Moss (JM)	Chief strategy and transformation officer, NHS North East London
Louise Ashley (LA)	Chief executive, Homerton Healthcare NHS Foundation Trust
Archna Mathur (AM)	Director of specialised services and cancer, NHS NEL Acute Provider Collaborative
Chetan Vyas (CV)	Director of quality, NHS North East London
Sarah See (SS)	Managing director of primary care, NHS North East London
Marie Price (MP)	Director of communication and involvement, NHS North East London
Anne-Marie Keliris (AMK)	Head of governance, NHS North East London
Dianne Barham (DB)	Chief executive, Healthwatch Waltham Forest *for item 2.0 via MS Teams*
Katie McDonald (KMc)	Governance manager, NHS North East London
Apologies:	
Shane DeGaris (SD)	NHS trust partner member
Caroline Rouse (CR)	VCSE partner member
Diane Jones (DJ)	Chief nursing officer, NHS North East London

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting including members of the public who had joined the board meeting to observe either in person or via the MS Teams virtual link.

	The Chair advised people of the fire alarm procedure and other housekeeping matters before proceeding.
1.1	Declaration of conflicts of interest
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the ICB. No additional conflicts were declared. Declarations declared by members of the ICB are listed on the ICB's Register of Interests. The Register is available either via the Governance Team or on the ICB's website.
1.2	Minutes of the last meeting
	The minutes of the meeting held on 25 January 2023 were agreed as a correct record.
1.3	Matters arising
	The Chair requested an update regarding the development of progress trajectories rather than Red, Amber, Green (RAG) ratings in relation to the framework for performance reporting. HB advised that this work has started and that trajectories are available as an appendix to the performance report.
1.4	Action log
	The ICB Board noted the actions taken since the last meeting.
2.0	**Resident story**
	DB presented 'Sanjay's story', a pseudonymised description of a resident's experience within urgent and emergency care and community care settings. The story highlighted the importance of the system working together and how, when it does not, the pressure this creates in Accident and Emergency (A&E). Key points from Sanjay's story included: • An initial misdiagnosis led to multiple A&E attendances until it was discovered Sanjay had heart disease and required surgery. Sanjay was discharged and advised to wait at home until a planned surgery was arranged. • At home, Sanjay suffered a heart attack and required emergency heart surgery. • Following discharge, Sanjay was advised that district nurses would be arranged to provide wound care but unfortunately this did not happen. This led to the wound bleeding and requiring treatment and multiple ambulance call outs. • Sanjay also developed respiratory symptoms and was told by his GP surgery that no appointments were available; despite being a vulnerable patient with heart disease. After insisting, he received a telephone consultation and a prescription for antibiotics which resulted in him feeling distrustful of his diagnosis and treatment. • Sanjay was keen to highlight that he was not dissatisfied with his care and felt he had been well looked after by his GP and hospital staff. Members discussed Sanjay's experience and made the following comments:

	• Residents should be encouraged to pass this level of feedback to their GP as lessons could be learnt and therefore improve quality of care and patient experience. • It would be beneficial for residents to have a single point of contact following surgery who can address any concerns or worries they have, as residents experience heightened stress and anxiety post-surgery. • Broadening the virtual ward model could be considered as this offers a single point of contact and has had proven successful at Barts Health. • The story did not include whether Sanjay accessed any services provided by the voluntary sector, however these services should be considered as residents will require clinical and non-clinical support. • It could be helpful to review how other regions manage post-surgery patients as this could inform our modelling. • MG will contact 'Sanjay' directly to thank him for his contribution to this meeting. The ICB Board noted the resident story.
3.0	**Chair and chief executive reports**
3.1	Chair's report
	MG presented the report which provided an update on the most significant activities undertaken by the Chair and non-executives since the last ICB board meeting. The following key areas were highlighted: • The Chair thanked ICB staff for their continued dedication and contribution to the organisation given the recent national announcement regarding the reductions to the ICB running costs budget. Staff have been understandably concerned but have also been offering ideas and potential solutions. • The ICP Steering Group agreed that Councillor Neil Wilson should be appointed as deputy Chair of the group and recommended that the ICP committee also nominates a deputy Chair. The steering group considered a working draft of the Joint Forward Plan and provided some constructive feedback and also agreed that the ICP committee will hold a workshop focussed on coproduction. • A meeting was recently held with ICB Chairs and Chief Executives across London and unanimous agreement was secured to making a public anti-racist commitment. The Chairs and Chief Executives agreed that this needed to be a commitment with clear actions, with the content developed by each ICB to ensure relevance and meaning. The ICB Board noted the report.
3.2	Chief executive officer's report
	ZE presented the report and noted the following key areas: • The system been under significant pressure throughout the winter which will continue through into spring. To manage the pressures being faced, the North East London system meets together on variety of levels, including the daily emergency care hub meeting which assesses the level of risk on each site and manages mutual aid. • Concerted action has been taken across the system to minimise the impacts on patient safety of all days of industrial action. There have been four days of action in the ambulance service, and the local system coped well with the constraints. The 72-hour strike action by the junior doctors led to the rescheduling of around 600 planned care procedures and 8000

	outpatient appointments. This was required to release consultant staff to focus on urgent and emergency care patients. • At the beginning of March, NHS England wrote to all ICBs to inform them of reductions to ICB running cost allowances. All ICBs running costs allowances will remain the same in 2023/24 as 2022/23, necessitating a small reduction in costs to take account of inflation. More significantly there is a requirement to reduce running costs by 30% 2025/26 (with at least 20% to be delivered in 2024/25). Staff are aware of the recent information and the executive team is working through the detail of what this means ahead of a formal consultation which will commence from 18 April 2023. • The latest staff survey results have been published nationally this month. These present a snapshot view of the organisation during October and November and some further work is ongoing to analyse the key themes and findings in more detail so that an action plan can be quickly agreed. An item will be presented to the Workforce and Remuneration Committee regarding the survey results. • The proposed corporate objectives for 2023/24 build on the transitional objectives agreed in July 2022. Workforce was highlighted as a key enabler for all areas of work, and the commitment to support the delivery of becoming an anti-racist ICS will be an area of key focus for the Board. Members discussed the report, with key points including: • The staff survey results and any key actions should be communicated back to the Board via the Workforce and Remuneration committee's exception report. • It was recommended that the corporate objectives contained further reference to our residents and the operating plan. The Chair agreed to have a further conversation with ZE regarding this outside of the meeting. • Engagement on the workforce strategy has started with system colleagues, including local authority chief executives and directors of adult social care. An update on the strategy will be presented at a future board meeting, following a report to the workforce and remuneration committee. • There is a need to be as integrated as possible and relieve tensions in order to focus on the system priorities and ambition following the reduction in running costs. **ACTION:** Chair and ZE to discuss the corporate objectives further and consider reference to local residents and the operating plan. The ICB Board noted the report and agreed the proposed corporate objectives for the Board during 2023/24, subject to the outcome of discussions between the Chair and Chief Executive as detailed above.
4.0	**Strategy**
4.1	Joint forward plan – March submission
	JM presented the report and explained: • The report contains the first draft of the joint forward plan which reflects that the partnership has further work to do in order to develop a cohesive and complete action plan for meeting all the challenges being faced in the system. • There is a commitment to work with local people, partners and stakeholders to iterate and improve the plan as the partnership develops, including annual refreshes to ensure it stays relevant and useful to partners across the system.

	• There are three key strategic challenges that are affecting the ability to improve population health and inequalities, and to sustain core services in the system over the coming years which are poverty and deprivation, population growth and the national investment available. • Learning has been identified by collating information from place, however further work is required to ensure existing transformation programmes align with each other. *Sarah See joined the meeting at 2.15pm.* Members discussed the joint forward plan, with key points including: • The terms 'equity', 'equality' and 'inequality' appear to be used interchangeably, therefore further thought should be given to the terminology that is used within the plan. • Consideration should be given as to how the longer-term impact of the Covid-19 pandemic can be reflected within the plan, including the related social issues. • It would be beneficial to have a version of the plan which uses language that is easily accessible to residents and the health and social care workforce in order to promote to local communities. • The commitment with the Mayor of London should be referenced within the plan. • As part of the next stage, demonstrating priorities to residents will need to be considered. Creating a dynamic triangle could be a useful tool to depict this. • It would be helpful if the plan included the increased workload within general practice and that there has been no additional funding to support this. • There has been a contract change in primary care which has impacted on longer term Local Incentive Schemes and is, therefore, a commissioning gap which is a risk. • The maternity transformation section could have greater emphasis on the population of north east London and a focus on black women's maternal health from an equity perspective. The ICB Board approved the plan for submission to NHS England.
4.2	Financial strategy
	HB presented the report and explained the following key points: • The approach represents a significant shift in the way funding is allocated across north east London and seeks to support the twin goals of financial stability and supporting all organisations and partnership forums to transform and improve services for our population. The approach will support the Integrated Care Partnership's five-year strategy and allocate resource in line with that strategy. • The new financial framework will need to iterate over time as the organisation 'learns by doing' and it is recognised that much of the detail is NHS North East London as part of a wider system financial framework and are keen to work with partners to develop it further. • Following collaborative discussions with chief finance officers across the system, growth assumptions have been applied at a contract level of 50% of national assumptions which has created an investment pool for 2023/24 of £22.9m. In 2023/24 this pool may also need to be used where we have unfunded commitments, however the ambition for later years is to increase the size of the investment pool (to 1% of the NHS NEL budget received

	from NHSE) and to ensure that it is more closely targeted at truly new transformation/services. • Remaining revenue allocations and associated savings requirements will be made to place committees of the ICB, to trusts, or be held centrally by the ICB. The Board discussed the strategy with key points including: • It would be beneficial to hold a workshop with system partners, including the voluntary sector, to discuss how each sector's finances operate in order to enable a shared understanding. • Understanding the totality of resource has been beneficial and provided a greater understanding of the system as a whole. • The national funding formula is not reflective of north east London's population; therefore, consideration should be given as to whether there is any scope for changing the formula. • Understanding cost within all parts of the system will be key as this will assist in determining areas for prioritisation. Having this level of transparency between partners is essential but may be uncomfortable for some organisations. • Consideration should be given as to how the strategy and its implications can be communicated to local residents. • A commissioning framework should be developed to support Voluntary, Community and Social Enterprise (VCSE) organisations to deliver health and care services and for when they are working on behalf of the NHS. **ACTION:** HB to arrange a system workshop to develop shared financial understanding of each sector. The ICB Board endorsed the approach.
5.0	**Quality**
5.1	Deep dive: Urgent and Emergency Care
	PGi presented the urgent and emergency care (UEC) deep dive and highlighted the following key points: • It is important to understand what is meant by urgent and emergency care and NHS England have published the two commonly used definitions: o Urgent care involves any non-life-threatening illness or injury needing urgent attention which might be dealt with by phone consultation through the NHS111 Clinical Assessment Service, pharmacy, primary care. o Emergency care involves life-threatening illnesses or accidents which require immediate treatment from the ambulance service (via 999) and an emergency department (A&E). • On 30 January 2023 a national UEC recovery plan was published, which sets out the NHS performance aims for the years 2023/24 and 2024/25. The key measures of success in the national plan are: o A response time to category 2 ambulance calls of 30 minutes o 76% of patients to be treated and discharged or admitted through Emergency Department (ED) within 4 hours • The operational plan for 2023/24 is required to set out how the system will deliver these targets. The plan also requires the ICB to develop plans for a capable and responsive System Control Centre (SCC), which is currently provided in virtual form. Work has begun to assess data sources, quality and completeness, and consideration is being given to potential uses of

	current commercially developed platforms to enable the future SCC to predict system pressure and clinical risks. • It is important to ensure that local people in north east London access this care in ways that work for them and improve outcomes. Through the Community Insights System led by Healthwatch local people's views have been gathered on their experiences of trying to access and use all parts of urgent and emergency care. The Quality, Safety, and Improvement Committee considered the issue of patient engagement as part of its review of resident access to UEC at its meeting on 8 February 2023. The follow up was agreed to take place through the UEC Programme Board which is chaired by the ICB Chief Medical Officer. • GP Access Hubs manage same day urgent care within primary care, in part to reduce the pressure on Urgent Treatment Centres (UTCs) and Accident & Emergency (A&E). These have been very effective at supporting access and reducing pressure on other parts of the system, however national/ regional funding for GP Access Hubs comes to an end this financial year. • A piece of work will be undertaken to capture the learning from this winter and put in place an improved system resilience plan for next winter. The ICB is working with social care colleagues to ensure the best use of discharge funding and to better understand demand and capacity as a system. • In response to BHRUT and PELC's CQC inspection, a quality summit was convened by NHS England in December 2022, bringing together system partners to agree a series of actions to address all aspects of the CQC findings. Board members discussed the deep dive report and comments included: • It would be beneficial to have greater transparency regarding the outcomes on performance and to receive assurance from the Quality, Safety and Improvement Committee that the position is improving from a quality perspective. • It could be helpful to expand the UEC conversation to outside of the north east London footprint and into areas such as Haringey and Essex as there are residents who access UEC services that are out of area. • Once metrics and success measures have been agreed, a further report will be presented to the Board which will include a timeline for ambitions. • Further work is required to work with and educate residents to explain what alternatives there are to attending A&E and that other health professions, not just doctors, can help them receive treatment. The ICB Board noted the report. *At this point the ICB Board members and attendees received a comfort break and the meeting reconvened at 3.10pm.*
6.0	**Pharmacy, optometry and dentistry services delegation programme**
	JM and SS presented the report and explained the points listed below: • From 1 April 2023 NHS England will delegate responsibility to all ICBs for all pharmaceutical, general optometry and dental services (POD) which means that there is an agreement between NHSE and NEL ICB that enables the ICB to take on the responsibility for delivering NHSE functions. The ICB becomes the operational and legal owner of the function, being both responsible and liable for its delivery, with NHSE retaining accountability to Parliament.

	• Following two options appraisals conducted in September 2022, the five London ICBs, along with the London Regional Team, agreed a 'Lead Commissioner' operating model, with North East London ICB taking this leadership role on behalf of all the London systems. • The memorandum of understanding (MOU) between NEL ICB and the four London ICBs has been reviewed by colleagues working in finance, quality, legal, human resources and complaints. This MoU establishes that the five ICBs have determined that NHS NEL ICB will act as the "Host ICB", hosting the central POD Hub, that will be responsible for co-ordinating the commissioning and contracting of POD services on behalf of all five ICBs. The MOU has been agreed and signed off by the four other London ICB Boards. • Each ICB shall receive its own Financial Allocation for POD services, meaning that the financial risk to NEL ICB for hosting the service is minimal. • One of the benefits of hosting the service is that budgets for dentistry have been historically underspent in north east London, therefore this provides opportunities for place partnerships to utilise the funding. The ICB Board discussed the report with key discussions including: • Some residents have reported a two month wait to receive a dental consultation, therefore this presents a real opportunity for boroughs to improve equality of care. • There is a lot of neighbourhood potential as a result of this and it could be beneficial to include clinical pharmacists in this work too. • Financial costs have not been reflected within the report which is a point of concern in light of the requirement to reduce ICB running costs. It was requested that the next Audit and Risk Committee exception report to the Board should reflect any concerns and assurances. **ACTION:** Audit and Risk Committee to report to the Board regarding any implications of the POD services within its future exception reports. The ICB Board: • Approved the establishment of the new operating model and a London-wide oversight group through which the five London ICBs will oversee the work of the newly established POD Hub within NEL ICB. • Noted the 'Letter of Comfort' in place with NHS England for the period of 1 April – 30 June while the POD Commissioning Team remains employed by NHSE London Region. • Approved of the memorandum of understanding between NEL ICB and all other ICBs from 1 April. • Approved the delegation agreement with NHS England and the Scheme of Delegation for NEL ICB to be updated accordingly.
7.0	**Joint working model with NHSE for Specialised Services for 2023/24**
	PGi and AM presented the report and highlighted the following points: • On 2 February 2023 at its Board meeting, NHS England approved plans to commission jointly with Integrated Care Boards, 59 service areas (some but not all specialised services) from April 2023. • Following discussion between ICB Chief Executives and NHSE London, through the existing Partnership Board, it was agreed that London will have a single joint committee; this will allow for co-ordinated decision making between ICBs and NHSE during this transitional year.

	• Within north east London, the Acute Provider Collaborative will deliver the specialised service programme on behalf of the ICB, optimising the expertise of specialist clinicians and teams to drive economies of scale across NEL, improve care for local populations and working in a matrix on end to end pathway redesign with place to improve LTC management and prevention, aiming to reduce the future financial risk and demand on specialised services. • The Joint Working Agreement is a stepping stone to full delegation that ensures the ICB and Trusts are closer to designing and shaping specialised services, bringing together clinicians, operational teams and clinical networks to redesign services to meet local population needs. • The clinical priority areas of focus for 2023/24 in north east London are renal care, haemoglobinopathies (sickle cell), specialist paediatrics, neurosciences, HIV opt out testing and liver disease. These priority areas are based on population need and requirement to reduce existing clinical inequality within the local population. • Resources to deliver the specialised service delegation programme are a key risk as the delegation is not accompanied by NHSE resource. This is because the management of a significant number of highly specialised service lines will be retained by NHS England. Resource mitigations are in place with a resource plan submitted to the ICB for consideration alongside the forthcoming staff consultation for which approval is pending. • NHSE expects to implement a 'needs-based' allocation model in a phased way from 2024/25, with 'pace of convergence' safeguards to ensure systems do not see destabilising changes in funding levels. • There is experience within the system in regards to receiving specialised services from NHS England as this has happened recently with mental health services. Colleagues in the Acute Provider Collaborative are working with those within the Mental Health, Learning Disability and Autism Collaborative to share learning and experience. The ICB Board discussed the report with key discussion including: • North east London undertakes a significant amount of work for residents outside of the area, therefore this could result in a reduced income for our NHS Trusts. • The delegation will enhance opportunities for resident involvement in regards to redesigning pathways. • The model is exciting and presents further opportunities within the prevention space and could improve access issues between acute Trusts. The ICB Board approved the Joint Working Agreement and joint working arrangements for the commissioning of specialised services in 2023/2024, thus authorising the ICB Chief Executive to sign the document on behalf of North East London ICB enabling new commissioning arrangements for specialised services to go live from April 2023.
8.0	**Finance and performance overview**
	HB presented the report and highlighted the following areas: • The ICS have reported an unfavourable system variance to plan at month 10 of £44.2m, primarily due to inflationary pressures and slower than planned delivery of system savings and cost improvements. • The ICB and system partners have been in discussion with regulators about a movement from a break-even position to a year-end deficit position. It has been agreed that the year-end system deficit will be £35m (£34m provider

	deficit and £1m ICB deficit). If this position is achieved, it will result in NHSE releasing £10.5m resource, resulting in a final year-end deficit of £24.5m. It is expected that this resource will be received in month 12 but it is assumed as an income source in the month 10 position. • The overall referral to treatment waiting list fell in November 2022 due to a decrease in the number of patients waiting for treatment in an outpatient setting. • The number of patients being seen in north east London remains lower than planned, particularly in relation to inpatient activity. Inpatient activity in November 2022 was 95% of 2019/20 levels. Consultant led outpatient activity was at 104% of pre-pandemic levels in November 2022. • Patients were able to initiate their own follow up appointments (PIFU) with the aim to reduce un-needed appointments and booking of follow-up appointments by default for 1.3% of all outpatient appointments in November 2022, the highest volume in north east London to date. • In November 2022, north east London delivered five of the nine cancer waiting time constitutional standards for patients. However, treatment for patients within 62 days from urgent GP referral still requires improvement. • Productivity programmes are in place at all three NEL acute Trusts (at hospital site level) with the aim to improve inpatient activity via improved theatre productivity and utilisation. As a system, NEL ICB is working to reduce long waiters, with focus on ensuring all patients waiting over 26 waits are reviewed and/ or have a date, managed via the local recovery programme. Members discussed the report, with key points including: • The financial position is very challenging which raises concerns regarding the implications this could have on the next financial year. It could be beneficial to have an external or London-wide peer review to identify whether there is anything further that could improve the position. • There is a risk that short-term fixes are more desirable in order to meet targets, however consideration needs to be given to the longer-term implications. • Contracts appear to have different content in terms of covering pay awards which may require further review. HB agreed to discuss this further with MG outside of the meeting. • The recommendation to approve the delegation of authority for the signing of contracts and contract variations to the Chief Finance and Performance officer and one other chief executive will be considered at the next meeting as part of the Governance Handbook review. **ACTION:** HB and MG to discuss contract variation further outside of the meeting. **ACTION:** The recommendation to approve the delegation of authority for the signing of contracts and contract variations to the Chief Finance and Performance officer and one other chief executive to be included as part of the Governance Handbook review. The ICB Board noted the report as well as the risks to the financial position and key risks of delivery.
9.0	**Governance**
9.1	Board Assurance Framework
	CPo presented the report and noted the following key points:

	• The framework has been refined and updated following the feedback received at the March Board meeting and subsequent meeting of the Chair, Audit Chair and lead executive on 28 February. • Updates included the realignment of some risks against the strategic ICS aims, an edit of wording to bring greater clarity and inclusion of four additional risks covering mutual accountability for the operating plan, the anti-racist commitment, digital and estates infrastructure; and focus on being outward looking as well as NEL focussed. • The last Audit and Risk Committee considered the internal audit review of governance and risk, which included some recommendations for improvement which will be addressed in the next version. Members discussed the report with key points including: • The updated risks are more reflective of the organisation's priorities and is a positive improvement. • Further consideration is required in relation to detailing the mitigations in place to address the air quality risk in north east London. The ICB Board noted the report.
9.2	Committee exception reports for information
	The chairs/ vice-chairs of the committees of the Board each presented an exception report which highlighted the work undertaken by its members since the last meeting. The reports included updates from: • Executive committee • Audit and risk committee • Workforce and remuneration committee • Quality, safety and improvement committee • Finance, performance and investment committee • Population health and integration committee. The ICB Board noted the exception reports.
10.0	**Board forward plan**
	The ICB Board noted the forward plan.
11.0	**Questions from the public**
	There were no questions received from members of the public.
12.0	**Any other business and close**
	There were no further items for discussion.
	Date of next meeting – 31 May 2023

NHS
North East London
Integrated Care Board

ICB board – action log

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
1.3 Action log	25 Jan 2023	Chair of the Quality, Safety and Improvement Committee to share a first draft of what the format for a future quality report should be with the board chair to ensure the content meets the requirements of the board.	IR/ DJ	July 23	A draft report is being developed which will be shared for comment with the Quality, Safety and Improvement Committee prior to presenting to the Board.
6.0 Finance and performance overview	25 Jan 2023	Further discussion to take place outside of the meeting on what would need to be included in a quality report to the board going forward and the constitutional standards information that needs to be included in the performance report in order to achieve the right balance.	HB/ DJ	July 23	Linked to action above.
3.2 Chief executive officer's report	29 Mar 2023	The Chair and Zina Etheridge to discuss the corporate objectives further and consider reference to local residents and the operating plan.	MG/ ZE	May 23	Complete.
4.2 Financial strategy	29 Mar 2023	Henry Black to arrange a system workshop to develop shared financial understanding of each sector.	HB	July 23	In progress. As work on the financial strategy progresses, plans for a system workshop will be worked through.
6.0 Pharmacy, optometry and dentistry services delegation programme	29 Mar 2023	Audit and Risk Committee to report to the Board regarding any implications of the POD services within its future exception reports.	CPa	May 23	Audit and Risk Committee Chair will report by exception as appropriate.

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
8.0 Finance and performance overview	29 Mar 2023	Henry Black and the Chair to discuss contract variation further outside of the meeting.	HB/ MG	July 23	A report on the proposed changes to the Scheme of Reservation and Delegation will be presented to the Board in July.
8.0 Finance and performance overview	29 Mar 2023	The recommendation to approve the delegation of authority for the signing of contracts and contract variations to the Chief Finance and Performance officer and one other chief executive to be included as part of the Governance Handbook review.	HB/ CPo	July 23	As above - a report on the proposed changes to the Scheme of Reservation and Delegation will be presented to the Board in July.

CLOSED ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
1.3 Matters arising	30 Nov 2022	Progress on resident stories to be followed up.	CP	March 23	Complete.
3.1 Chair's report	30 Nov 2022	Clinical leadership to be added to the agenda for discussion at a future meeting.	PG	March 23	Complete. Added to board forward plan for May 2023.
1.3 Matters arising	30 Nov 2022	Progress on resident stories to be followed up.	CP	March 23	Complete.
3.1 Chair's report	30 Nov 2022	Clinical leadership to be added to the agenda for discussion at a future meeting.	PG	March 23	Complete. Added to board forward plan for May 2023.
3.2 Chief executive's report	25 Jan 2023	The Chair asked for feedback on how our Emergency Preparedness, Resilience and Response (EPRR) compliance rating compares to ratings given to other ICBs.	HB	March 23	A briefing will be circulated to members.
4.1 Interim Integrated Care Strategy	25 Jan 2023	JM to take the discussion points forward.	JM	March 23	Complete.

CLOSED ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
		A draft ICB Estates Strategy to be presented to the board at a future meeting.	JM	July 2023	Agenda item scheduled for March 2023.
4.2 Joint Forward Plan	25 Jan 2023	Final draft Joint Forward Plan to be presented to the board at the next meeting.	JM	March 23	Complete. Agenda item scheduled for March 2023.
4.3 Deep dive into primary care	25 Jan 2023	A further wider primary care deep dive was requested for a future meeting based on quality and how we can improve variation from a patient perspective working with Healthwatch and the voluntary sector.	DJ/ PG	July 23	Agenda item scheduled for July 2023.
5.1 Board assurance framework	25 Jan 2023	A meeting to be arranged involving the ICB Chair, Cha Patel, members of the Governance Team and other relevant executive colleagues before the next board meeting to discuss how the BAF could be developed even further.	CP	March 2023	Complete. Meeting held on 28 February 2023.
7.2 Audit and risk committee exception report	25 Jan 2023	A report to be presented at a future board meeting on the processes that our system partners have in place for 'speaking up'	DH/ DJ	May 2023	Agenda item scheduled for May 2023 meeting.
8.0 Board forward plan	25 Jan 2023	The following to be added to the board forward plan: • Regular deep dives • A further deep dive on the wider primary care - focussed on quality and how we can improve variation in services from a patient perspective working with Healthwatch and other voluntary sector colleagues. • Quality report. • Board development session agenda items for information going forward.	CP	March 23	Complete. Items scheduled on board forward plan

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Chair's Report
Author	Marie Gabriel
Presented by	Marie Gabriel – Chair
Contact for further information	Marie Gabriel, Chair Marie.gabriel1@nhs.net
Executive summary	• Key issues: This paper is focused on outcomes from meetings of the North East London Integrated Care Partnership and the North East London Non-Executive community. The Board is asked to consider these outcomes to inform our conversations at our meeting. • The Report also highlights our system co-production and continuous improvement ambitions and how they relate to and will inform national work. • Recommendation: To receive and note the report, in particular the appointment of Councillor Neil Wilson as Deputy Chair of the North East London Integrated Care Partnership.
Action required	For noting
Previous reporting	North East London Integrated Care Partnership meeting on 5 April North East London Non-Executive Meeting on 11 May
Next steps/ onward reporting	• ICP Steering Group and Non-Executive views are taken into account • Further report on continuous improvement to be brought to this Board after consideration by the Integrated Care Board Executive and the Integrated Care Board Executive Committee
Conflicts of interest	None
Strategic fit	• To improve outcomes in population health (Focus on non-executive system leadership, co-production and continuous improvement) • To tackle inequalities in outcomes, experience and access (Focus on non-executive system leadership, co-production and continuous improvement) • To enhance productivity and value for money (through continuous improvement, non-executive system leadership, and ongoing work to balance the budget) • To support broader social and economic development (through co-production and Integrated Care Partnership work).
Impact on local people, health inequalities and sustainability	Through our work on co-production and by seeking to inform best practice and national priorities we are ensuring national work incorporates key outcomes that are meaningful for our local people.

Impact on finance, performance and quality	Through developing the voice and the role of the non-executive community as system leaders, we are supporting the delivery of shared outcomes and embedding mutual accountability and ambition across the North East London NHS landscape.
Risks	We are mitigating the risk that national priorities do not align with local priorities by proactively informing policy and practice, and ensuring we are focusing on risks to patients and communities through the Integrated Care partnership and the engagement of Non-Executives.

1.0 Introduction

1.1 I want to begin this report by acknowledging the hard work of all our system leaders in achieving a financially balanced operational plan, whilst staying true to our local ambition and the four aims of an integrated care system. At the meetings with national colleagues, we were able to successfully raise the impacts of population growth and our lower level of capital allocation and I am pleased to say there is to be a follow-up conversation about both of these, hopefully before the summer. The joint endeavour of our system was clear and our focus on using our resources productively to secure the best outcome for residents is our continued focus.

1.2 The report informs the Board of the key points arising from North East London Integrated Care Partnership April meeting and North East London Non-Executive Workshop held on 11 May, to ensure their views are taken into account in Board decision making. It also updates the Board on NHS@75 ambitions.

2.0 Integrated Care Partnership

2.1 At its 5 April meeting the North East London Integrated Care Partnership agreed that Councillor Neil Wilson should act as my Deputy for the Partnership as well as for its Steering Group. My thanks to Councillor Wilson for his willingness to take on this role and I look forward to working with him. The Partnership also approved the terms of reference for its Steering Group, which has been established to guide the work of the partnership. These are available on our website. The main focus on the meeting was on co-production and presentations that highlighted co-production in action were received from Spotlight, East London NHS Foundation Trust, Enabled Living Healthcare and the Ilford Exchange Health and Care Centre. A Partnership development workshop followed which considered our Joint Forward Plan cross cutting theme of co-production, with the emphasis on securing a joint understanding and identifying necessary system action. In summary the meeting reached several key conclusions.

- The need to recognise that co-production can and should be different in different places, organisations and communities
- The need for the system to harness and share best practice from within the system and also to look to effective models from elsewhere, for example the ‘Ladder of Empowerment’.
- That co-production should be throughout and should focus on working ‘with’ people and not ‘doing to’ people
- That borough/place-based arrangements should be defined by co-production and should embed their own models, including a recognition of the importance of the Community Chest established by the ICB to enable this.

- Co-production is built on trust, so we must be able to evidence change and ensure that every voice is heard
- We should create participation panels that will include all system partners that are relevant, including areas such as education or housing so that our people and community can hold us to account for participation that enables effective integration and improved outcomes
- We need a clarity of language used and demonstrable impact / outcome
- A recognition in Voluntary, Community and Social Enterprises (VCSEs) that expertise comes in many forms such as professional, educational and lived experiences
- A recognition and openness about limitations, including what is possible to change and on budgets for example some statutory organisations may not be given enough time to design the service fully, therefore they need to devise ways of ensuring adequate time for co-production
- Recognise voluntary and community sectors as an asset for co-production
- There needs to be an identified infrastructure within the ICS to support co-production. This includes support for recognition of expertise and reward to ensure inclusivity, helping to reduce hierarchy to make sure all views are valued
- We need to support people in the system and locally through training and development.

3.0 Chair and Non-Executive Activities

3.1 On 11 May, Non-Executives from across North East London met to discuss their role in system leadership. We received external presentations from Caroline Clark, the NHSE London Regional Director and from Saffron Cordery, Deputy Chief Executive of NHS Providers who provided a regulator view and national learning.

3.2 There was a great deal of energy in the room, with shared support for a focus on prevention to secure local term sustainability, this included a focus on root causes and shift from in-patient to community-based care. There was also a push to clearly deliver, to recognise and be transparent about our mutual accountability to each other and also to our shared population to improve. Key points arising from the workshop are listed below.

• Better engagement of Non-executive Directors in setting strategy/working with the system and improved communication with Boards on progress against strategy.

• The need to simplify. Please can we identify a few key system challenges, (as defined by our people including front-line staff), identify the shared outcomes, establish joint programmes and share progress in one year. This would further build trust with each other and with our communities.

• For Trust Boards to consider the representation of system around their Board table and how Trust Boards focus on system working through their governance.

• All Boards or their equivalent, to actively consider how we move from competition to collaboration and be more intentional about system working and mutual accountability.

• Maximising transparency about our budgets at system and place and use those resources to work differently, addressing inequities and ensuring clinical and professional strategy aligns.

• Boards to consider identifying the investments their individual organisation can make for joint benefit.

• Ensure we are a learning system including identifying and building on what partnership and system projects are doing well.

• There is a role for Boards, in addition to the ICB Board, to consider how the different collaboratives and place-based partnerships they lead/participate in are joined up.

• The need to ensure that provider and place collaboration structures are less complicated and ensure that they do connect with and make sense to the front line.

• We need to develop clarity on how we resolve disagreements, and agree strategic trade-offs.

• In discussion about risks, it was recommended that principles are needed so that our focus is on risk to patients, so that we move from organisation to system risk. We should also use those risk principles to improve how we categorise risks and agree a system risk appetite.

• We also need to consider the transfer of risk with transparency on cost and clarity on accountability and on clinical benefit.

• We need to identify our system capital priorities and, within this, we need to invest in digital and to consider how we pool our estate.

• The need to consider how we could make training for our health careers more affordable for our local residents and to consider whether we can we set a target for employing people with lived experience.

• We need practical, action focused solutions for workforce challenges.

• Ensure that we consider how digital transformation can support our workforce challenges.

3.3 The Chairs and ICB non-executives subsequently met with the Integrated Care Board Chief Executive and Chief Finance and Performance Officer and have developed a mini plan of action as a result which we are in the process of writing up so I will speak to next steps at the meeting.

3.4 Many of my conversations over the last two months have focused on improvement. Board members will recall that our development session focused on a system wide approach to improvement, building on what happens already within the system and drawing on international best practice to develop a common language and set of tools that will help us all, including our people and communities to improve outcomes together. This is very much the how of delivering against our purpose and the ICB Executive team will work with system colleagues to turn the principles within our outline framework into a firm proposal for action. Our away day was already planned before the publication of a report by NHSE on the need for continuous improvement, which can be found at NHS England » NHS delivery and continuous improvement review: recommendations. The report, featuring ELFT as best practice, recommends launching a single shared NHS Improvement approach, the establishment of a national improvement board to agree a small number of shared national priorities on which NHS England, with providers and

systems, will focus our improvement-led delivery work on and the co-design of a leadership for improvement training programme. The emphasis on the small number of national priorities is in line with the recommendations of the now published Hewitt Review, a summary of which has been separately shared with Board members.

3.5 The development of shared national priorities for improvement can also be seen in the launch of work connected to NHS 75th birthday. I am part of a small system and provider advisory group to the NHS Assembly, which is seeking to shape a new emphasis for the next stage of the NHS's life. Our first task was to inform a rapid engagement exercise which will result in a short report to be published on the NHS's actual birthday, 5 July. The report will aim to summarise key learning from the NHS's recent past, outline where we are today and set out the priorities for key future developments. This report will be a foundation for shaping a renewed purpose for the NHS. Further details can be found at NHS Long Term Plan » NHS Assembly

3.6 The Non-Executive Members and Associate Non-Executive Members, have agreed to take on Lead Borough Roles, which will enable us to have a better understanding of our individual places to inform our contributions. Non-Executive Members will be, or will have already been, in touch with Place Delivery Directors, Clinical Leads and key local partners as part of this lead role. The Borough Leads are set out below for information.

Barking and Dagenham	Kash Pandya
City of London	Cha Patel
Hackney	Imelda Redmond
Havering	Marie Gabriel
Newham	Diane Herbert
Redbridge	Sue Evans
Tower Hamlets	Noah Curthoys
Waltham Forest	Fiona Smith

4.0 Recommendation

4.1 The Board is asked to receive and note the report, in particular the appointment of Councillor Neil Wilson as Deputy Chair of the North East London Integrated Care Partnership.

Marie Gabriel – Chair
07/05/2023

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Chief Executive Officer's Report
Author	Zina Etheridge, Chief Executive Officer
Presented by	Zina Etheridge, Chief Executive Officer
Contact for further information	Laura Anstey l.anstey@nhs.net
Executive summary	The following report provides an update on our continued development of NHS North East London.
Action required	To note
Previous reporting	N/A
Next steps/ onward reporting	N/A
Conflicts of interest	N/A
Strategic fit	The report aligns to the strategic purpose, priorities and objectives of the ICB and ICS. • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The ICB will enable us to have greater impact as we are enabled to work in a more integrated way across health and care organisations in north east London.
Impact on finance, performance and quality	N/A
Risks	N/A

1.0 Introduction

1.1 Since the last board meeting I have been focused on a number of key priorities – continuing to strengthen relationships and cement the role of the ICB, launching the consultation on our ICB structure and working with the London region and national team to manage our key priorities including the system financial position and urgent and emergency care pressures. The following report outlines highlights from the last period.

2.0 System resilience

2.1 We are already planning ahead for next winter and looking at our system resilience and what more we need to do to put in place a system level response. We are undertaking some detailed reviews on what is working well and which areas need additional support. These include community pharmacy, how best to utilise clinical decision makers and balance pressures in primary care with further bolstering services like NHS 111 and how to best leverage data and analytics as well as being clear about the role of the ICB in managing the system pressures. We are holding a summit in May to discuss further with system partners.

Linked to this is our continued focus on supporting the outer north east London boroughs with urgent and emergency care following recent Care Quality Commission (CQC) inspections. Clear actions plans are in place at both Barking, Havering and Redbridge University Hospitals Trust (BHRUT) and the Partnership of East London Co-operatives (PELC), with progress being made in the key areas identified in the inspections.

2.2 **Industrial action and pay offer**

Over the last two months we have continued to manage ongoing pressures arising from industrial action. There was disruption to patient care in the ambulance service (now resolved), and by non-consultant medical staff. Although emergency services were repeatedly disrupted, pressures were managed and the main impact was the postponement of patient operations, investigations and appointments. Significant short-term harm to patients has been avoided and the north east London Clinical Advisory Group is reviewing this. There will also be a longer-term study London-wide.

The NHS response was co-ordinated across London, and led locally by a multi-disciplinary incident management team, chaired by Francesca Okosi, Chief People and Culture Officer. We are now looking at lessons learnt particularly in terms of how urgent patients could be redirected to services other than emergency departments (ED).

In addition to the above, in early May the north east London system provided mutual aid to south east London, which was severely impacted by the nurses' strike. While pay negotiations continue, we are now preparing for the potential impact of further nurses' strike action in the summer.

3.0 Operating plan

3.1 Work has continued through April to land a break-even position on the system finances in our final operating plan submission. As a system we have worked collaboratively to identify ways to manage the pressures, identify savings and provide mutual aid and support. The balanced overall system position includes some organisations in significant deficit, largely in the acute provider sector, offset by surpluses elsewhere. Whilst the operating plan is balanced overall it contains an unprecedented level of financial risk and represents a significant challenge to deliver.

In April we met with NHS England to discuss our plans and outline our proposed way forward and have subsequently sought consensus on next steps as a system. We are now focused on a recovery programme and a revised approach to managing pressures as a system going forward, already planning ahead for the expected challenges next year.

4.0 ICB organisation restructure

We launched the formal consultation process on the new size and shape of the ICB on 18 April – this is open for 45 days and sets out proposals for how we will shape our teams to deliver the ICB's purpose and align ourselves around its new functions. The proposed restructure also sets out how we will meet the financial envelope we have been set for the next financial year. The consultation closes in early June and we will then spend a period of time reviewing the feedback and revising the proposals ahead of signing off the final structures.

6.0 Working with our partners

6.1 **Workforce strategy workshop**. At the end of April, we brought together partners from trusts, primary care, local authorities and the voluntary sector to discuss and agree key strategic themes, priorities and initiatives for our integrated people and workforce strategy and how these can be enabled through collaboration at Neighbourhood, Place and System by our Acute Providers, Mental Health, Primary Care and Voluntary and Community collaboratives.

The workshop held detailed conversations in breakout groups. Each group covered a unique topic which had been identified from prior stakeholder engagement. The discussions included evidence of good practice that we can build upon to further develop the strategy for the benefit of all staff, intending staff and NEL Populations.

We are collating themes and outputs from the discussion groups which will feed into finalising a High-level People and Workforce Strategy for sign off.

This will form the basis for the next phase of working to co-design a detailed system-wide People and Workforce strategy delivery action plan.

Some of the key discussions centred around

- Bringing in (Inclusion and Representation) - What can we do to make health and care careers attractive to young people and under-represented groups in our local populations, including carers, people with disabilities and people who have been economically disadvantaged
- Bringing on (Developing and Nurturing for Success) - Pockets of good innovative, collaborative workforce initiatives already happening across the system and which areas where there is duplication across the system and in our collaboratives, could benefit from a joined up, system-wide solution to promote economies of scale and what interventions should be held at different levels
- Bringing Together (System Progression, Collaboration and Integration) - What assumptions have we built the current system on that are no longer sustainable based on population demand, which we need to deconstruct in order to reconstruct different workforce solutions with different ways of working
- We have been able to gather information from the rich discussions to build the high-level People and Workforce Strategy and will work together with our stakeholders to co-design a detailed system-wide five-year People and Workforce strategy delivery action plan.

6.2 **North East London MP meetings.** We have continued our programme of regular meetings with our local MPs and Marie Gabriel and I convened a further system wide meeting in April focused on primary care. Key topics raised included GP

appointments, dentistry, vaccines, demand and capacity and recruitment to the primary care workforce. It was a really constructive discussion and a subject MPs are really passionate about. We have a regular schedule of these meetings bi-monthly to ensure we are addressing the key issues being raised by constituents across north east London. I am also continuing with Marie Gabriel, our series of 2:1 conversations with MPs.

6.3 **ONEL JHOSC –** In April the Joint Health Overview and Scrutiny Committee (JHOSC) took place – this brings together representatives from the individual scrutiny committees for Barking and Dagenham, Havering, Redbridge and Waltham Forest to consider local NHS developments and changes that impact the local authorities collectively. We attend as a system so I was joined by colleagues from BHRUT, NELFT and primary care. The latest session covered topics including the recent CQC inspections of urgent and emergency care at BHRUT and the urgent treatment centres – with a jointly owned presentation by the ICB, BHRUT and PELC, which was really positive in demonstrating to members how we are working together as a system to take collective responsibility and address key issues. Follow up questions from councillors included what it means for patients and how the system is working together to address the key issues. There was also an item on primary care enhanced access and how we are working to ensure residents have the right access to GP appointments.

7.0 System visits

7.1 **ELFT service visit** – In April I spent time visiting services run by East London Foundation Trust. I met with the community mental health team on the Isle of Dogs and the Children and Adolescent Mental Health Service (CAHMS) in Tower Hamlets and heard about the co-production they have done with service users, the deep links they are forging with communities and how they are working dynamically as teams to improve their ways of working.

8.0 Promoting the work of the ICB

8.1 I recently spoke on a panel at the King's Fund annual integrated care system conference about the impact of the cost of living crisis on local people. This was a good opportunity to showcase some of the work we have been doing as an ICB as part of our wider work on addressing health inequalities. I outlined key findings from the GLA survey and our work on asthma inhaler uptake which found that inhaler use is reducing in those who pay for prescriptions. I also outlined the work our places have been doing on the cost of living crisis as they have such an important role to play in the health of our communities.

Zina Etheridge
May 2023

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Operating Plan and 2023/24 ICB Budget
Author	Steve Collins, Director of Finance
Presented by	Henry Black, Chief Finance and Performance Officer
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Executive summary	**Key Items** • The operating plan was submitted on 4 May 2023. • Performance and activity were in line with previous submissions. However, financial plans were updated to reflect the outcome of system wide discussions involving Chief Executive Officers, Chief Finance Officers and the regulators. • The system has submitted compliant targets in urgent and emergency care (UEC), cancer, people with a learning disability and autism. The targets which are non-compliant are in community health services (partially compliant in relation to the virtual ward target), elective care and diagnostics (not compliant against the outpatient follow up target), mental health (not compliant against Improving Access to Psychological Therapies (IAPT), perinatal and access to Children and Young People's (CYP) services) and primary care (not compliant against dental activity). • The workforce submission plans for significant growth of substantive staff and reductions in bank and agency. • The key change to the finance plan was the movement from a system deficit of £73.1m to a breakeven position. • Within the overall breakeven plan, Barts have a deficit, BHRUT and Homerton are close to breakeven and the ICB, ELFT and NELFT are all delivering a surplus to offset the deficit. • The ICB planned surplus is £15.4m. • The plan includes a significant level of risk at £209.5m that is currently unmitigated. • Additionally, there are £277.8m efficiencies built into the plan, with a risk of delivery slippage. • If any of the risks materialise this may impact on the delivery of the breakeven position.

	• The operating plan and budgets were presented to Finance, Performance and Investment Committee (FPIC) on 30 May 2023. A verbal update will be given to ICB Board on the recommendation made by FPIC.
Action required	The Board are asked to: • Note the verbal update from FPIC on the operating plan and 2023/24 budget. • Approve the operating plan and 2023/24 ICB budget.
Previous reporting	ICB FPIC
Next steps/ onward reporting	Future financial and risk updates will be given to the ICB Board, ICB Finance, Performance and Investment Committee and the ICB Audit and Risk Committee.
Conflicts of interest	No conflicts of interest
Strategic fit	NEL wide plans are set on the financial resources available. The report provides an update of the operating plan and 2023/24 ICB budget.
Impact on local people, health inequalities and sustainability	Update of financial sustainability and performance of the system. Specific performance indicators address performance against the needs of those with protected characteristics (as defined by the Equalities Act) such as disability and that is included in the report.
Impact on finance, performance and quality	Delivery of the financial plan and meeting the control total and delivery of performance metrics and constitutional standards are mandated requirements.
Risks	Key risks have been identified as delivering efficiencies, managing the level of unmitigated risk and run rate pressures including inflation, agency usage and winter pressures. Performance risks are flagged in relation to non-compliant performance trajectories in CHS, elective care and diagnostics, MHS and primary care.

ICB Board – Operating Plan and 2023/24 ICB Budget

1. Purpose of the Report

The purpose of the report is to update the ICB Board on the operating plan submitted on 4 May 2023 and highlight the changes made to the finance submission.

The ICB Board is recommended to approve the operating plan and the 23/34 ICB budget.

2. Operating Plan

2.1.1 – Performance update - ICS

The following section gives a brief update on the operating plan performance targets.

Elective and diagnostics

- 109% Elective Recovery Fund (ERF) achieved.
- Acute providers are expected to clear all waits over 65 weeks by the end of 23/24.
- Activity levels in the diagnostic modalities exceed 100% of Business as Usual (BAU).

Cancer

- NEL is required to achieve a backlog of below 7% in aggregate (patients waiting over 62 days by March 2024), currently the backlog is 7.4%. NEL have submitted a trajectory that will meet the target.
- NEL have submitted a compliant trajectory against 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- NEL have submitted compliant trajectories for early diagnosis through prevention awareness and screening. Additional initiatives span across the diagnosis and treatment workstream to ensure timely access and treatment.

Urgent and emergency care

- All Trusts have submitted compliant trajectories to deliver 76% standard by March 2024. There are various schemes around admitted and non-admitted pathways across all sites to support delivery of this target.
- Additional capacity funding has been approved by NHS England which build additional bed capacity in the hospitals to support delivery of the bed occupancy and A&E targets.

Community services

- NEL continue to submit a trajectory to deliver on the 70% Urgent Community Response (UCR) contacts within 2 hours and have sustained this performance in 23/24 trajectories. Further work is being undertaken to increase referrals through UCR to support with front door pressures.
- Virtual Ward currently at 23 bed per 100,000. The trajectory for 23/24 is 30 beds from April to December and deliver the target of 40 by March 2024. This will be a stretching target, however a key area of focus for the community collaborative.
- There are no targets set for community waiting lists, however the main concern for NEL is Children Services waiting lists. The community collaborative agreed that speech and language is an area of focus and deep dive which is the driver of the longest waits.

Primary Care

- NEL GP appointments will increase by an average of 3% in 23/24 compared to 22/23. Although targets have not been set for each place continued support will be

given to local systems to understand variation and inequalities through reviewing performance including data and coding at a practice level. This will inform development of local pathways in and out of primary and urgent care to scope the needs of local patient cohorts.

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

Mental Health and Learning Disability

- IAPT and perinatal mental health have a non-compliant trajectory. Further resources will be required in future years to achieve these trajectories.
- CYP - CYP Urgent Care expansion is not expected to increase access, some places need to expand duration of treatment to meet rising acuity.

2.1.2 – Workforce and governance update - ICS

- Providers are planning significant growth of substantive staff across all main staff groups and significant reductions in bank and agency to meet operational plan requirements.
- Proactive sickness absence management and improved rostering practices to deliver efficiencies.
- The ICB will work with providers on theatre utilisation programme to increase productivity from 65% to 85%.
- During 23/24 Primary care plan to achieve 90% conversion of trainees within the system and ensure that PCN and GP employers have access to workforce planning tools and information.
- Across the ICS there will be a workforce productivity group to provide oversight of monitoring against the plan.

2.1.3 – Finance update - ICS

- The ICS operating plan submitted on 4 May 2023 showed a movement from a system deficit to a system breakeven position.
- This represents a £73.1m improvement from the plan submitted on 30 March 2023.
- Within the overall breakeven plan, Barts have a deficit, BHRUT and Homerton are close to breakeven and the ICB, ELFT and NELT are all delivering a surplus to offset the deficit.
- The table below shows the movement from a system deficit to a breakeven position.

	ICS £m	ICB £m	BHRUT £m	Barts £m	ELFT £m	Homerton £m	NELFT £m
Plan Submission March - Surplus / (Deficit)	**(73.1)**	**0.0**	**(19.5)**	**(50.0)**	**0.0**	**(3.6)**	**0**
BHRUT stretch	9.0		9.0				
MH non-recurrent support	10.0				4.2		5.8
ICB measures	13.7	13.7					
Non-recurrent additional allocation	13.3		5.1	6.2		2.0	
NHSE support for excess inflation	11.3		3.0	7.7		0.6	
IFRS 16 revenue funding	0.8	0.1	0.0	0.1	0.1	0.2	0.2
Specialist Commissioning growth	5.4		0.8	4.3		0.3	
Stretch balance required for system breakeven	9.6	1.6	1.4	3.8	1.1	0.7	1.0
Total Plan Submission May - Surplus / (Deficit)	**0.0**	**15.4**	**(0.2)**	**(27.8)**	**5.4**	**0.2**	**7.0**

- The ICS finance plan has required significant non-recurrent actions to close the gap. This will create a risk to the underlying position in future years.
- Efficiencies of £278m are required to balance the plan.
- Potential risks with no identified mitigations of £209.5m have been identified – the main risks flagged are in relation to the delivery of efficiencies, run rate pressures including inflation, price and activity increases, staffing pressures and additional winter pressures.
- The table below shows the efficiencies and risks across the system.

	Efficiencies £m	Unmitigated Risk £m
BHRUT	(32.0)	(13.0)
Barts	(106.4)	(119.5)
ELFT	(20.8)	0.0
Homerton	(17.8)	(15.0)
NELFT	(18.2)	0.0
Provider Total	**(195.2)**	**(147.5)**
ICB	(82.6)	(62.0)
ICS TOTAL	**(277.8)**	**(209.5)**

2.1.4 – Finance update and 23/24 Budget - ICB

- The ICB submitted a planned surplus of £15.4m in 23/24.
- The detailed plan included a split of programme and running cost expenditure. All areas of spend have had the operating planning technical assumptions factored in and efficiency targets have been included in the relevant programme area. It is assumed that the mental health investment standard will be met.
- The ICB is expecting to receive an allocation of £4,217.7m in 23/24. Expenditure plans have been developed, totalling £4,202.3m resulting in a planned surplus position of £15.4m.
- The table on the next page shows the ICB budget split by programme and running costs.

Plan Detail	Plan £m
Recurrent Allocation	4,042.5
Non-Recurrent Allocation	175.2
Total Allocation	**4,217.7**
Planned Expenditure	
Acute	(2,311.1)
Mental Health	(448.9)
Community Health Services	(444.5)
Continuing Healthcare (CHC)	(186.4)
Primary Care and Prescribing	(314.5)
Delegated Primary Care	(392.9)
Other Programme Services	(22.4)
Other Commissioned Services	(43.0)
Running Costs	(38.7)
Total Expenditure	**(4,202.3)**
Planned Surplus / (Deficit)	**15.4**

- To deliver the surplus the ICB has included a high level of efficiencies and has reviewed all planned investments and System Development Funding (SDF). Slippage and delays to investment have been factored into the plan and some SDF has been used to support baseline expenditure. The total amount released into the plan in relation to investments and SDF is £13.7m.
- The ICB has £82.6m of efficiencies within the plan. Of this £51.6m are expected to be delivered non-recurrently. Additionally, there is £1.6m of efficiencies that are yet to be identified. This relates to the additional stretch added to the ICB position in order for the breakeven position to be achieved.
- The delivery of non-recurrent efficiencies impact on the underlying exit rate of the ICB is 23/24. Therefore, although the ICB plans to deliver a surplus in 23/24 the recurrent underlying position is a deficit in the region of £49m.
- The ICB has £62m of outstanding risk, with mitigations yet to be identified. The highest value risk to the ICB relates to delivery of efficiencies (£48.8m). The ICB has RAG (red, amber, green) rated efficiencies and delivery is deemed to be high or medium risk. There is also £13.1m risk in continuing healthcare and prescribing. This is in relation to ongoing inflationary pressures and activity and price increases.
- If any of the risks flagged in the operating plan materialise this will impact upon the ICBs ability to deliver a £15.4m surplus
- The table on the next page shows details the efficiencies required to deliver the surplus and the risks to the financial position.

Area of Expenditure	Scheme	Recurrent £m	Non Recurrent £m	Total £m	Risk Rating	Efficiency Risk / Mitigations £m	Other Risks / Mitigations £m	Total Risk / Mitigations £m
Continuing Care	CHC	(11.0)	(4.0)	(15.0)	High	(8.5)	(6.6)	(15.1)
Prescribing	Prescribing	(5.1)	(12.0)	(17.1)	High	(11.5)	(6.6)	(18.1)
NHS Property Services	Property Services	(1.1)		(1.1)	Medium	(0.5)		(0.5)
Non Recurrent Programmes	Non Recurrent Benefits		(27.0)	(27.0)	High	(13.5)		(13.5)
Programme Projects	Programme corporate	(6.0)		(6.0)	High	(4.5)		(4.5)
Running Costs	Running Costs (5%)	(1.9)		(1.9)	Medium	(1.0)		(1.0)
Programme Projects	Agency Control (Q2)	(3.0)		(3.0)	Medium	(1.9)		(1.9)
Programme Projects	Consultancy Spend		(1.0)	(1.0)	Medium	(0.3)		(0.3)
Programme Projects	Recruitment delay		(6.0)	(6.0)	Medium	(4.5)		(4.5)
Acute Reserves	Repatriation/ERF (Acute)	(3.0)		(3.0)	Medium	(1.5)		(1.5)
Non Recurrent Programmes	Unidentified risk		(1.6)	(1.6)	High	(1.2)		(1.2)
Non Recurrent Programmes	Unidentified mitigation					48.8	13.1	62.0
TOTAL		**(31.0)**	**(51.6)**	**(82.6)**		**0.0**	**0.0**	**0.0**

3. Summary

- The 23/24 financial position for both the ICS and ICB is extremely challenging with a high level of risk associated with the delivery.
- The ICB Chief Finance and Performance Officer is leading discussions around financial recovery across the system. This will centre on a system wide recovery plan that aims to enable each organisation to achieve financial balance within a reasonable timescale.
- Whilst significant elements of delivery will be at a local level there will be significant inter dependency across organisations and collaboration will be required to deliver cross pathway transformation.
- To enable system working to be delivered to its optimum full visibility and transparency will be required from all organisations.
- Updates will be given to the ICB Board and FPIC throughout the financial year.

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Making north east London a Living Wage system
Author	Rebecca Waters, Health Improvement and Inclusion Manager Rebecca.waters@nhs.net
Presented by	Francesca Okosi, Chief People and Culture Officer
Contact for further information	Rebecca Waters, Health Improvement and Inclusion Manager Rebecca.waters@nhs.net
Executive summary	This paper sets out a proposal for north east London Integrated Care System (NEL ICS) to commit to becoming a London Living Wage system across our geography, including for NHS Trusts, primary care, local authorities and social care providers. In order to qualify for this recognition, senior leaders across the ICS must commit to working towards the aim to implement the London Living Wage. Health Education England and the London Recovery Board were anticipating that 100% of NHS employers in London would, by 31st March this year, have committed in principle to paying their staff the London Living Wage (LLW). At the time of writing London has achieved the target of 75% of NHS Trusts making this commitment. As a system, we are asked to make a commitment to paying the LLW over this year. The LLW is currently £11.95 per hour and all NHS staff employed on Agenda for Change (AfC) terms are paid at least at this rate. However, we believe that making a commitment across our wider system to the LLW would be a contributory factor in reducing the strain of the current cost of living crisis on residents including those in our health and care workforce, on achieving greater parity across health and care and on delivering high quality services. This paper sets out progress to date in achieving our LLW system ambitions, identifies what further actions need to be undertaken and asks the ICB to endorse the commitment to work towards becoming a LLW ICS.

Action required	The ICB is asked to: • Reconfirm their commitment, as per the anchor charter, for the ICS to become a London Living Wage system • Support the development of a programme of work to ensure implementation and to galvanise progress towards accreditation • Note that oversight of the programme will be held via the NEL People Board and be linked to the emerging Workforce Strategy
Previous reporting	NEL ICB EMT – September 2022 NEL People Board – November 2022 NEL DASS forum – February 2023 Executive Committee of the ICB Board - 9 March 2023.
Next steps/ onward reporting	To continue to develop an effective implementation plan, working through the NEL People Board.
Conflicts of interest	There are no known conflicts of interest.
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To support broader social and economic development
Impact on local people, health inequalities and sustainability	An equalities impact assessment has not been undertaken. By providing the LLW via all health and care employment routes in NEL we believe we can contribute to improving the health of the local population. As part of this work, we would like to identify how many of the health and care staff that we directly and indirectly employ also live in NEL. Providing the LLW to our population puts them on a stronger financial footing in order to make more sustainable consumer decisions and enable them to adapt to better cope with the effects of climate change.
Impact on finance, performance and quality	The costs of implementation have not yet been fully calculated, so whilst there are no immediate additional resource implications/revenue or capital costs arising from agreeing this report, it is anticipated that the costs of some provision will increase significantly as the supply chain moves towards paying London Living Wage over time.

Risks	We believe paying LLW across our system would support one of the ICS priorities around employment and workforce, which is to work together to create meaningful work opportunities and employment for people in north east London now and in the future. As we work towards this aspiration, there is a risk that parts of the system will be able to move faster contributing to an uneven approach.

1. Introduction

1.1 This paper sets out a proposal for North East London Integrated Care System (NEL ICS) to commit to implementing the London Living Wage across the north east London geography, including NHS Trusts, primary care, local authorities and social care providers. It describes current progress in achieving accreditation across the system and the actions needed for NEL to make further steps towards becoming a LLW system during 2023.

1.2 Health Education England and the London Recovery Board were anticipating that 100% of NHS employers in London would, by 31st March this year, have committed in principle to paying their staff the London Living Wage (LLW). At the time of writing London has achieved the target of 75% of NHS Trusts making this commitment. As a system, we are asked to make a commitment to paying the LLW over this year.

1.3 The LLW is currently £11.95 per hour and all NHS staff employed on Agenda for Change (AfC) terms are covered by the LLW. The wider challenge of ensuring that all temporary staff, employees of external contractors and those delivering the full range of health and care services are also receiving the LLW as a minimum is recognised at a London and sub-regional level.

2. Background

2.1 By committing to becoming a London Living Wage system, we would support delivery of the NEL Anchor Charter priority of *'Widening access to employment, training and providing the best working experience'.* All partners across the system have signed up to our Anchor Charter and we are now keen to convene providers to share learning and develop an action plan, including for the delivery of London Living Wage.

2.2 As a large employer across north east London the NHS has a role to play in building the capability to ensure that we are paying staff and contractors a liveable wage. This will support people to maintain a better quality of life that can reduce health inequalities, support good mental and physical health and in time reduce pressure on the health and care system. Making a commitment to the LLW would be one contributory factor in reducing the strain of the current cost of living crisis on residents including those in our health and care workforce.

2.3 By working towards the NEL health and care system paying all staff LLW we will also contribute to London being declared a Living Wage City. There is a growing body of evidence that wage floors are productivity enhancing, helping increase employee effort, reduce absences and employee turnover and increase recruitment and retention, as well as leading to better organisational practices.

2.4 NHS NEL has been approached to participate in a piece of work with the NHS Confederation and Institute of Public Policy Research to support development of a framework to support all ICSs nationally on understanding better the broader social and economic impact of ICSs. Paying the LLW could support the ICS and all its constituent members to deliver on these responsibilities and to make sustainable investments in the places in which we deliver services.

3. Work to date: north east London

3.1 We have been working across the system to map progress in implementing LLW in our geography. We acknowledge that we are not yet meeting the London wide hospital trust targets and we are working together to meet our wider targets for accreditation and implementation.

3.2 For each Trust we have an understanding of our baseline position, have spoken to the LLW leads within each of our Trusts and have established a programme approach with project support to enable delivery and to ensure we understand both the barriers and opportunities to moving forward.

3.2.1 Whilst there is still some way to go, work is underway in each of the Trusts to support progress towards full accreditation and each Trust is on the pathway towards becoming a LLW organisation. We note that for those partners, notably NELFT and ELFT which also have operations outside London, there is an aspiration to achieve Living Wage status across their delivery footprint.

3.3 We recognise the significant challenges to building a sustainable approach to paying LLW across primary and social care. These sectors, whilst distinct, are similar in that they consist of a huge number of individual employers with different organisational structures and practices, and there is no pre-existing framework such as Agenda for Change in place as it is across the NHS. Based on initial conversations we recognise the commitment to the concept of the LLW but also note the concerns that contracts are not funded at a level to consistently provide LLW rates. By working with organisations to better understand the costs of implementation, the existing employment models, sector specific issues and risks associated we hope to be able to increase our accreditation levels in these sectors.

3.3.1 As we carry out a significant care market review across north east London, we have agreed to incorporate work on LLW to our overall picture of capacity and sustainability across the care sector.

3.3.2 As we move towards implementation of the Fuller Stocktake and transition to local commissioning of Dentistry, Optometry and Pharmacy services, we are planning a dedicated primary care sub group to capture the challenges and develop a baseline of how many primary care providers are paying the LLW, in order to map a clear route to implementation.

3.4 Our overall approach, therefore, is to develop a system wide action plan to increase the number of health and care organisations achieving LLW accreditation. This will include increasing the uptake of organisations registering their intent to become accredited with the LLW foundation and scoping opportunities to include LLW in contracting and procurement through social value in procurement assessments.

4. Risks and mitigations

4.1 This is a complex area of work given the scale and variety of health and care providers working across north east London. We are very conscious of the financial challenges being faced already across our geography and the pressures on capacity, on recruitment and on retention as set out in our emerging Workforce Strategy. Whilst there are clearly identified benefits to paying the London Living Wage we acknowledge that there is no dedicated additional funding to enable an uplift to wages and indeed fees to ensure all employees across our supply chain are receiving LLW.

4.2 Our work is building from a commitment across the system to work with our workforce and to build the capacity and capability we need. We are mindful of our ICS priority around employment and workforce commitment, which is to work together to create meaningful work opportunities and employment for people in NEL now and in the future.

4.3 As described in our Workforce Strategy, there is a need to build greater parity of esteem across our whole workforce in a system wide approach – enabling payment of the LLW is part of this overall system approach. Whilst this work may risk further highlighting the lack of parity currently in place, we believe it is an essential stepping stone to achieving such parity over time.

5. Recommendations

5.1 In light of the above, we ask the ICB to:

- Reconfirm their commitment, as per the anchor charter, for the ICS to become a London Living Wage system
- Support the development of a programme of work to ensure implementation and to galvanise progress towards accreditation
- Note that oversight of the programme will be held via the NEL People Board and be linked to the emerging Workforce Strategy

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Deep dive: mental health & wellbeing in NEL
Author	Richard Fradgley
Presented by	Paul Calaminus, ICS SRO for mental health, learning disability & autism
Contact for further information	Paul.calaminus@nhs.net
Executive summary	This report provides the Integrated Care Board with an overview on mental health in children and adults in north east London. As a brief report, it presents a summary of need, risk factors, services, and strategic priorities for the Integrated Care System and the role of the Mental Health, Learning Disability & Autism Collaborative.
Action required	Note
Previous reporting	n/a
Next steps/ onward reporting	n/a
Conflicts of interest	n/a
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	NEL has amongst the highest levels of mental ill-health in the country, with clear evidence that poverty and inequality lead to poorer mental health. The link between good mental health and health and life outcomes is unequivocal.
Impact on finance, performance and quality	Considerable progress has been made in improving access, quality and outcomes for people with mental health conditions in north east London over the last four years, in line with the NHS Long Term Plan. However, NHS investment into mental health by weighted population is the lowest in the country in north east London. In the context of growing mental health need and demand and the Integrated Care Strategy priority for mental health, the Integrated Care Board is recommended to consider how mental health is resourced sufficiently into the future in order to maintain progress on access, quality and outcomes.
Risks	Mental health is everybody's business, and all ICS partners are critical to ensuring we provide high quality services and support for people with or at risk of mental health conditions in north east London now and into the future.

1.0 Introduction

1.1 The purpose of this report is to provide a brief insight into mental health in children and adults in north east London and how we are planning to improve outcomes across our geography. The paper presents a summary of context, what matters most to those who draw on our services, some of our service responses and strategic priorities and sets some questions for the Board to consider. We recognise the need to work together on our wider system response to improve mental health outcomes for our residents and communities, drawing on the clear and growing evidence of the impact of social determinants on mental health, which the pandemic has in many ways deepened and exacerbated.

1.2 The Board is asked to discuss the content of the report and consider any next steps to respond to improving mental health and wellbeing.

2. Context

2.1 Mental health affects how we feel, think and act, and has a profound impact on our day to day lives. It is intimately linked with wider health and life outcomes and is therefore integral to our overall aim as an Integrated Care System to work with and for all the people of north east London to create meaningful improvements in health, wellbeing and equity. Our 2023 Integrated Care Strategy identifies mental health as one of our four key priorities for action. Our approach encompasses the full range of mental health conditions, across all levels of severity from mild through to severe and enduring.

2.2 There is further information on need and prevalence in Appendix 1 and, with 24,600 people for example living with schizophrenia or bipolar disorder (2021/22 GP registers), north east London has amongst the highest levels of mental ill-health in the country[1]. Four of our seven places have the very highest levels of first episode psychosis in the country, which largely occurs in young adults. Those same boroughs also have amongst the highest levels of all serious mental illness in the country.

2.3 There is clear and growing evidence of the impact of social determinants on mental health, which the pandemic has in many ways deepened and exacerbated. In 2017, Thrive London mapped risk factors for mental health across London[2] - risk factors included 28 indicators including domestic violence, crime unemployment etc. Five of the eight highest risk areas in London are in north east London – these are Hackney, Waltham Forest, Newham, Tower Hamlets and Barking & Dagenham.

2.4 North east London is one of the most diverse populations in the country, with people of dozens of different ethnicities living in our boroughs. There is a very clear link between the impact of racism on mental health, for example in the fact that young black men are far more likely to be admitted to hospital under the Mental Health Act or be placed in seclusion[3].

2.5 We know from service users and carers just how important social circumstances are to quality of life and we also have outcome measurement tools which demonstrate

[1] https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness
[2] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366%2817%2930362-0/fulltext
[3] https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf

this. Supporting service users to address social factors in their lives has a positive impact on patient reported health and life outcomes.

2.6 People with serious mental illness die on average 15 years younger than the general population. There is a complex set of reasons, including poverty, the impact of social determinants more generally on health, and the impact of anti-psychotic drugs on weight, and higher levels of smoking in the population. Over the past several years, partly in the context of the pandemic, life expectancy for people with serious mental illness has reduced further[4] including in north east London.

3. Our approach and the ICS Strategy

3.1 Work to identify need and areas of focus across our system in 2021 identified that improving mental health and wellbeing outcomes for local people, of all ages, is one of our key priorities as a system. The north east London Integrated Care Strategy also identifies mental health as one of its four key priorities for action: To improve the mental health and wellbeing of the people of north east London. This is a deliberately broadly stated ambition which involves the whole system from creating environments where people feel safe to the provision of highly specialised in-patient services.

3.2 In November 2022, the north east London Mental Health Learning Disability &. Autism Collaborative supported service users and carers to design and facilitate a north east London Mental Health Summit to develop the key areas of focus for the mental health priority of the north east London Integrated Care Strategy. The focus on what matters to local people is fundamental to the way we want to work as a system and the outputs of the summit are set out in detail in Appendix 2.

3.3 Other key areas of the mental health priority include place-based priorities for mental health drawn from Health and Wellbeing Strategies and Place Partnerships which to a large extent focus on delivering mentally healthy places and earlier intervention, often located in communities rather than in more medicalised settings. Joint work with a range of partners, including across the NHS, local government and the voluntary and community sector is core to ensuring a consistent focus on the benefits and impacts of mental health on the way local people lead their lives. Our agenda is shaped too by the national requirements set out in the NHS Long Term Plan for mental health through to 2024/25.

3.4 In effect, the areas of focus identified and defined by those who draw on our services and our carers set out where we need to focus our quality improvement efforts and the Collaborative is now working on developing our delivery approach through the Joint Forward Plan. We are committed throughout our programmes to a patient leadership model which reflects our belief that we are working alongside rather than for those who draw on our services to improve outcomes.

3.5 Through the benefits of having the improvement of mental health and wellbeing as one of our four system priorities, we are able also to have a co-ordinated approach across the system to address the priorities for people who draw on our services, our place priorities and those set nationally. This remains work in progress, but we believe we need to focus on improvement across the following areas to ensure that:

- Service users and carers are active and equal partners in everything we do, across children and young people and adults

[4] https://www.gov.uk/government/publications/premature-mortality-in-adults-with-severe-mental-illness/premature-mortality-in-adults-with-severe-mental-illness-smi

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

4. Our services

4.1 Across the NHS, councils and the voluntary sector we collectively provide a huge range of services and support for people with or at risk of mental health conditions, from mental health promotion through to crisis care. Whilst the services vary from neighbourhood to neighbourhood and place to place (some of which is warranted, and some of which is unwarranted variation). North East London NHS Foundation Trust and East London NHS Foundation Trust provide the majority of NHS secondary care mental health services and are Care Quality Commission rated good and outstanding respectively. Some of the services and support we collectively provide are set out in Appendix 2.

4.2 In our 2023/24 operating plan for the NHS, we are planning to spend £436m on mental health. In the context of our very high levels of mental health need in north east London, we are working through our investment and testing this against other integrated care systems nationwide. We recognise the importance of our shared approach to meeting the needs of people with mental health needs and the contributions we can make through all our funding – including into acute and community services and primary care and through our local authority commissioning and delivery. Our Financial Strategy sets out our ambition to spend a higher proportion of our funding overall on prevention, early intervention and community-based provision recognising the benefits of this approach both in terms of outcomes and financial sustainability. We include our overall spend on mental health and wellbeing in this ambition - which we are keen to grow in a sustainable way as we build new models which support people to keep well in the community. We have work to do to ensure our overall balance of spend fully reflects the needs of our community and that all partners contribute to improving health and wellbeing outcomes across north east London.

5.0 System working and the north east London Mental Health Learning Disability & Autism Collaborative

5.1 The north east London Mental Health Learning Disability & Autism Collaborative is a collaboration between North east London NHS Foundation Trust, East London NHS Foundation Trust, North east London Integrated Care Board and the seven place-based partnerships including local authorities. The aim of the Collaborative is to improve outcomes, quality, value and equity for people with, or at risk of, mental health conditions or learning disability or autism in north east London. The Collaborative is overseen by a Committee of the Integrated Care Board chaired by the Joint Chair of North east London NHS Foundation Trust, East London NHS Foundation Trust.

5.2 The Collaborative intends that people participation will be at the heart of everything it does. To this end, four lived experience leaders have been formally recruited to become members of the Committee and are helping to shape the Committee focus and hold it to account.

5.3 The Collaborative is working with place-based partnerships to develop place-based mental health partnerships, taking responsibility for planning and delivering both place-based priorities for mental health and north east London wide priorities for mental health in a joined up, integrated way across partners – place-based mental health partners as they develop include service users and carers, health and care professionals and the voluntary sector. The Collaborative is also putting in place clinically led improvement networks across our seven places, where there is a priority or issue that can best be solved by working together across partners and across places. We currently have improvement networks for child and adolescent mental health, talking therapies in primary care (which is shortly due to launch its first north east London wide group treatment programme in Bengali and Albanian languages) and are developing networks for perinatal mental health, dementia and rehabilitation.

5.4 The Collaborative is currently undertaking a "diagnostic" to help understand in more detail the outcomes, quality, value and equity we achieve for mental health in each of our places for different populations. It is intended this will inform the development of a medium-term financial plan.

5.5 Finally, the Committee has overseen the approach to operational planning for 2023/24 and has developed a plan that supports us to continue our progress on the delivery of the NHS Long Term Plan for Mental Health in child and adolescent mental health, perinatal mental health, primary care talking therapies, community mental health services and dementia diagnosis. The plans for 2023/24 in particular focus on developing our urgent and emergency care pathways with an emphasis on outer-north east London places.

6.0 Conclusion

6.1 This report provides a brief overview of our context, the services we collectively provide and next steps on our strategy for mental health as a priority and the Collaborative as a key vehicle for delivery. Mental health is everybody's business, and all Integrated Care System partners are critical to ensuring we provide high quality services and support for people with or at risk of mental health conditions in north east London now and into the future.

6.2 In conclusion, we would like the Board to focus on the following questions for our system:

a. How can we work alongside local people to drive improvements in quality across mental health and wellbeing?

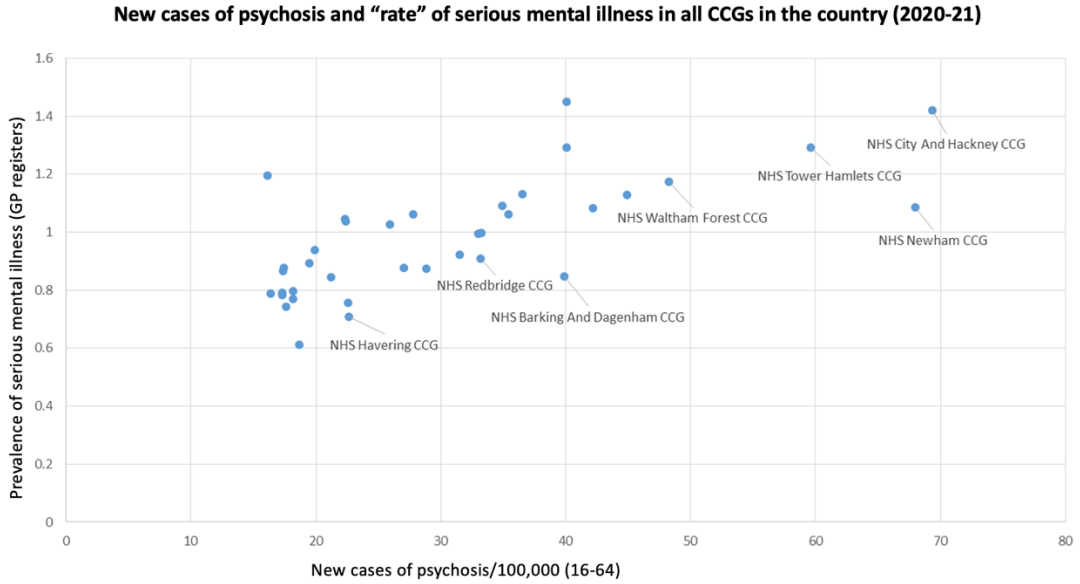
b. How do we ensure improving mental health and wellbeing remains a priority in all that we do as a system?

c. How do we best understand our overall spend and the impact of that on improving services?

d. How can we more effectively work to develop early intervention and mentally healthy places?

Appendix 1: Mental health and wellbeing in north east London

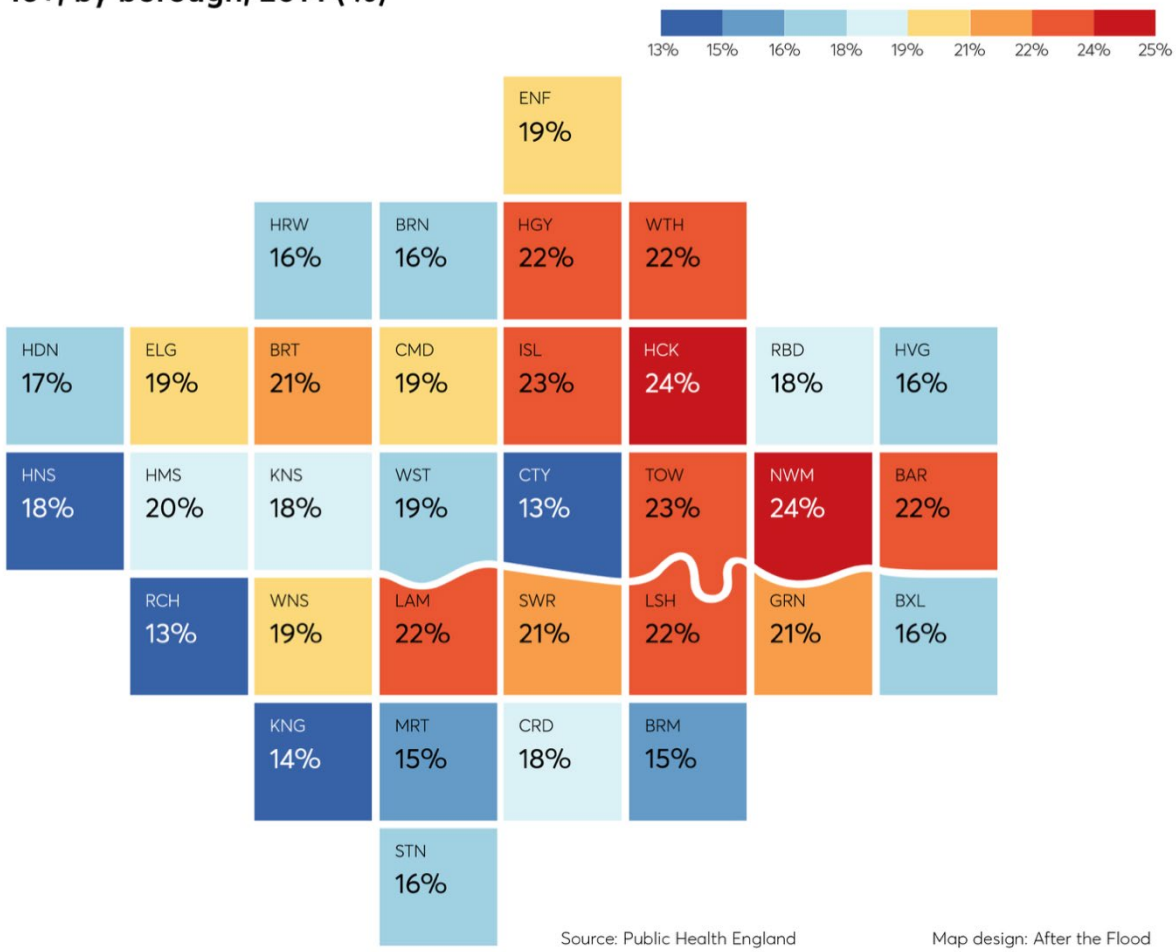
1.1 With 24,600 people living with schizophrenia or bipolar disorder (2021/22 GP registers), north east London has amongst the highest levels of mental ill-health in the country[5]. Four of our seven places have the very highest levels of first episode psychosis in the country, which largely occurs in young adults. Those same boroughs also have amongst the highest levels of all serious mental illness in the country.



1.2 There are over 150,000 people recorded on GP registers as having depression in north east London, again with amongst the highest estimated prevalence in London.

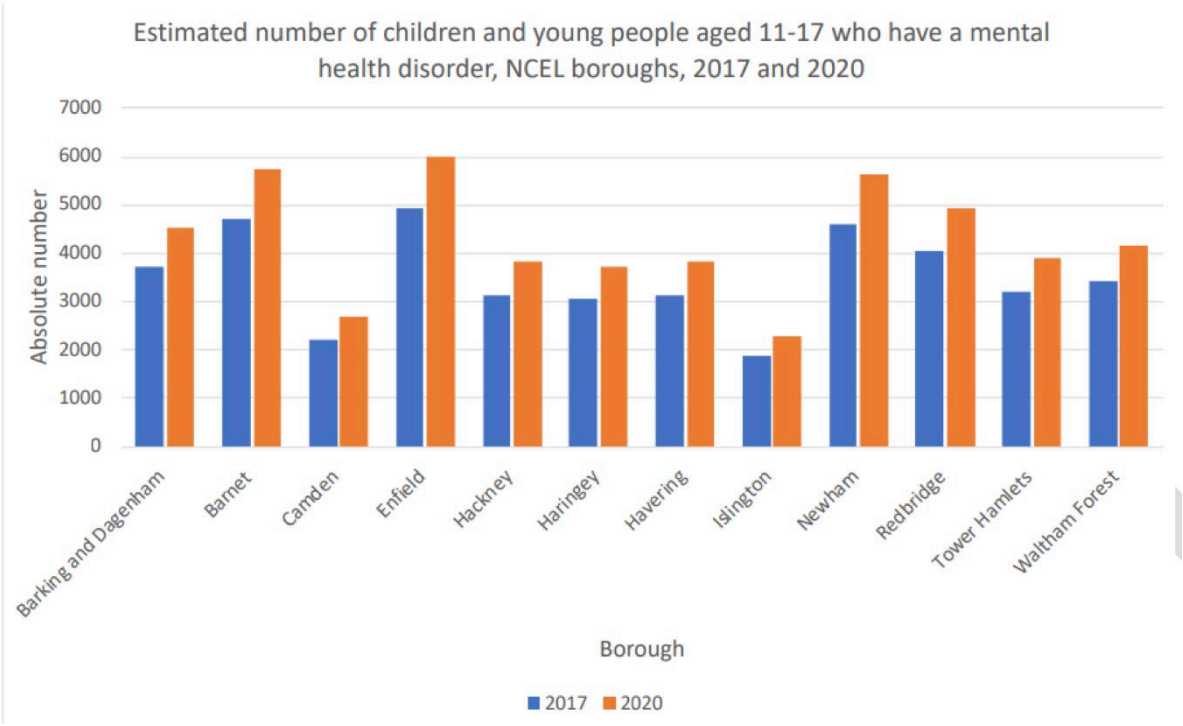
[5] https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness

Figure 8: Estimated prevalence of common mental disorders in adults aged 16+, by borough, 2014 (%)



1.3 There are 8,073 people living with dementia in north east London, according to General Practice registers, 42% of whom live in Havering or Redbridge.

1.4 We do not have accurate data on the prevalence of mental ill-health in children and young people due to lack of national and local prevalence, though a recent needs assessment indicates that there may be over 50,000 children and young people with mental health problems in North Central and East London.



1.5 In the context of the significant expected population growth and change in north east London over the next several years, we expect further growth and change in mental health need. There has been recent growth in adults requesting assessment for attention deficit hyperactivity disorder and children seeking support with eating disorders. We know also that there are very high levels of need for people with autism in both children and young people and adults.

1.6 Demand for mental health services in secondary care services has increased significantly in the context of growing need and is evident across health and care settings and providers.

1.7 Analysis currently underway through the North East London Mental Health Learning Disability & Autism Collaborative shows in more detail how some of the risk factors for mental health are distributed across London Integrated Care Systems, and within north east London.

Scoring of London boroughs and sectors against 'trustforlondon's' 19 poverty indicators

Category	Measure	Better = L,H	NEL	NCL	NWL	SEL	SWL	Newham	Barking and Dagenham	Tower Hamlets	Hackney	Waltham Forest	Redbridge	Havering	City of London
Living	Poverty rate	L	29.8	29.9	28.7	26.3	23.4	36.0	29.0	39.0	29.0	27.0	27.0	17.0	27.0
Living	Child poverty rate	L	43.8	33.2	32.5	33.7	30.0	49.0	46.0	51.0	45.0	43.0	38.0	33.0	10.0
Living	Income inequality	L	1.4	1.2	0.9	1.1	0.9	1.5	1.9	2.0	1.8	1.1	0.9	0.7	0.4
Living	Pay inequality	L	2.6	2.6	2.6	2.5	2.6	2.5	2.3	2.8	2.8	2.5	2.7	2.7	2.6
Housing	Homeless acceptances	L	1.1	0.6	0.4	1.1	0.7	1.9	0.7	0.7	1.3	1.3	0.9	0.6	0.5
Housing	Temporary accommodation	L	21.5	15.5	13.2	16.4	11.6	48.3	18.0	16.4	16.4	10.8	24.4	8.2	1.2
Housing	Evictions	L	2.8	2.5	2.4	2.3	2.3	4.5	4.1	1.6	2.2	3.0	2.8	1.9	0.9
Housing	Housing affordability	L	44.9	47.5	47.5	43.8	43.5	50.1	39.7	51.9	51.0	41.6	39.7	34.9	64.7
Housing	Housing delivery	H	157.8	128.0	109.7	199.9	149.9	80.0	80.0	420.0	170.0	190.0	80.0	40.0	0.0
Housing	Rough sleeping	L	237.2	291.1	385.1	254.7	159.8	428.0	131.0	297.0	229.0	153.0	247.0	69.0	372.0
Work	Low pay (resident)	L	22.1	21.9	20.7	18.2	17.8	24.5	26.3	20.2	22.2	17.7	23.0	21.6	20.2
Work	Unemployment rate	L	6.3	5.2	6.5	5.5	5.5	5.8	7.7	7.5	5.8	8.1	5.6	4.0	5.3
Work	Unemployment rate change	L	0.6	0.2	1.0	0.7	0.8	0.2	0.8	-1.0	1.2	4.2	0.0	-0.7	0.2
Work	Benefits	L	13.8	13.4	12.4	12.1	11.3	14.9	16.7	14.0	15.3	13.9	11.7	10.7	7.4
People	Qualifications at 19	L	30.0	30.2	25.9	33.8	32.5	29.2	38.7	26.8	30.3	30.0	22.1	37.0	24.4
People	Infant mortality	L	3.4	3.2	3.4	3.7	3.3	4.1	3.9	3.3	3.6	3.4	2.8	2.7	3.4
People	Premature mortality	L	354.5	302.0	301.3	336.5	318.2	385.0	449.0	350.0	366.0	329.0	298.0	323.0	316.0
Opportunity	GCSE attainment	H	74.0	75.8	77.9	74.1	75.2	74.3	70.1	74.4	73.6	68.7	79.5	76.1	75.6
Opportunity	No qualifications	L	6.8	5.6	6.7	5.5	4.9	6.1	12.0	6.5	6.9	3.5	7.4	6.9	6.7

Appendix 2: priorities identified by people who draw on services

1.1 Adults

What we need to do differently as a system

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

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

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

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

1.2 Children and young people

1. **Accessibility** - "I want the same chances at life as my peers without diversity, adversity or vulnerability, we aren't hard to reach "
2. **Coproduction** - ""I want to be actively engaged and supported to get involved and see changes that I have influenced"
3. **Distribution** - "I want the same experience and range of support regardless of where I live or go to school"
4. **Single front door** - "I want professionals to work together so that I tell my story once and be involved in deciding what support will suit me and my family's, goals and needs"
5. **Local offer** - "I want to be able to see all support available to me, my family and friends in one place"
6. **Diverse offer** - "I want to access support in different ways that suits me and my goals, not just what is available and not when it is too late"
7. **Universal offer** - "I want to understand and take ownership of improving my wellbeing and communicating my needs"
8. **Community referral**- I want to access a range of different activities that could improve my wellbeing and be supported to access them"
9. **Workforce** - "I want to be able to access different support from different people, including those with lived experience, when and where I need it"
10. **Transition** - "I want to feel like professionals care as I move between settings, different stages of my life or between professionals that support me and my family"
11. **Digital** – "I want to access support in different ways that suits me and my goals, not just what is available and not when it is too late"
12. **NEW Language** – "I want professionals to use language that has relevance to us, and stop the acronyms!"
13. **NEW Culture** - "I want professionals to know about my culture but to not make assumptions"
14. **NEW Independence** – "I want to be able to decide if/how my family are involved in my support, and they might also need support[25]"

Appendix 3: a snapshot of services

- Mental health promotion and prevention: provided primarily in our place-based partnerships across public health and other partners, with a north east London wide suicide prevention programme
- Mental health in general practice: it has been estimated that around 40% of GP appointments involve mental health[6]. GPs across north east London see people with mental health conditions, often alongside physical health conditions. Community mental health services are increasingly wrapped around primary care networks, with new Additional Roles specific to mental health working across primary and community mental health services
- Mental health in the voluntary sector: the voluntary sector is a critical partner in providing support along the entire mental health pathway, from prevention through to crisis care, and is particularly important in supporting people to access community services close to their communities and homes
- Mental health and the police: the police play a vital role in supporting people in crisis, with specific powers to do so. In some areas of north east London we have street triage services which involve mental health professionals co-located with and co-working with police officers which are very successful
- Children and young peoples' mental health services: we have a huge range of mental health services for children and young people, from our digital services provided by the voluntary sector, through to mental health in schools teams, community Child and Adolescent Mental Health teams, crisis services in development and inpatient services; working across children's social care and the NHS is particularly important for children most at risk. We plan to see over 27,000 children in our Child and Adolescent Mental Health services this year
- Perinatal mental health services: we have perinatal services working to support pregnant or new mothers and their partners, working closely with maternity services. We plan to see over 2800 people in our perinatal services this year
- Primary care talking therapies services: otherwise known as "Improving Access to Psychological Therapies" services, these services provide cognitive behavioural therapy and other therapies to people with common mental health problems (such as anxiety and depression) in primary care. We plan to see over 53,000 people in our primary care talking therapies services this year
- Community mental health services: we have had a particular focus over the last two years in developing our community mental health teams, which provide core health and social care community services for adults with moderate to severe mental health conditions. Increasingly organised around primary care networks/neighbourhoods, we provide a range of specific services around them, often in partnership with the voluntary sector, including recovery colleges, services to support people into work (Individual Placement Support), psychological therapies, services for people with eating disorders and complex emotional needs and for people with rehabilitation or forensic needs
- Community crisis services: we provide crisis telephone helplines, 24/7 crisis resolution home treatment teams, crisis cafes, and places of safety, with a crisis house in Tower Hamlets
- Older adults services: we provide community and inpatient services for older adults including those with dementia, including memory assessment and supporting the 2 hour response in community health services and enhanced health in care homes

[6] https://www.mind.org.uk/news-campaigns/news/40-per-cent-of-all-gp-appointments-about-mental-health/#:~:text=GPs%20say%20that%20two%20in,in%20the%20last%2012%20months.

- Inpatient mental health services: we provide over 250 inpatient beds including acute admission beds for adult men and women, psychiatric intensive care for men and women, and, commissioned by the North London Collaborative, specialist beds for people with forensic needs
- Mental health services in emergency departments and acute hospitals: we provide psychiatric liaison services in all of our urgent and emergency care departments and into the wards of each hospitals.

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Month 12 2022-23 finance overview and draft financial statement update
Author	Julia Summers
Presented by	Henry Black, Chief Finance and Performance Officer
Contact for further information	henryblack@nhs.net
Executive summary	**Key Items** • The final ICS year-end reported position is a deficit of £24m. This is approximately the same as the month 11 reported deficit. • The deficit position is driven by two system providers (Barts and BHRUT). Their combined deficit at year-end is £27.4m which has been partly offset by a reported surplus at ELFT, NELFT and Homerton, resulting in a provider year-end variance to plan of £24.1m. • The ICB have reported a very small surplus of £0.04m. • The pressures reported in prior months have continued to year-end. Providers have reported inflationary, efficiency and payroll pressures, whilst the ICB continues to see run rate pressures in continuing healthcare (CHC) and prescribing. These have been mitigated in part using non-recurrent measures but continue to be a risk moving into 2023/24.
Action required	• **Note** the content of the report.
Previous reporting	Finance, Performance and Investment Committee, and Audit and Risk Committee
Next steps/ onward reporting	Future financial and risk updates will be given to the ICB Board, ICB Finance, Performance and Investment Committee and the ICB Audit and Risk Committee.
Conflicts of interest	No conflicts of interest
Strategic fit	NEL wide plans are set on the financial resources available. The report provides an update of financial performance against the plan.

Impact on local people, health inequalities and sustainability	Update of financial sustainability and performance of the system.
Impact on finance, performance and quality	Delivery of the financial plan and meeting the control total is a mandated requirement.
Risks	There are no outstanding financial risks reported in 2022/23. These have been managed through delivery of non-recurrent mitigations. Even though the risk has been mitigated in 2022/23 there are still risks inherent in the underlying position of the ICB and wider system. Key risks identified are inflation, efficiencies and ICB run rate pressures within CHC and prescribing. Further system risk has been identified in relation to workforce and pay pressures with partners and system wide investment programmes.

1. Purpose of the Report

The month 12 finance report provides the Board with an update on the year-end financial position of both ICB and NEL system. Also included are the draft Financial Statements for the period ended 31 March 2023.

The Board is also recommended to note the submission of the ICB's draft Financial Statements to NHS England in line with the national timetable.

2. Month 12 Finance Overview

The month 12 year end position across the NEL system is a overspend variance to plan of £24m. System providers have a reported a variance to plan of £24.1m and the ICB has reported a very small surplus of £0.04m.

The reported year-end position is summarised by statutory organisation in the table below.

Organisations	Year-end Outturn		
	Plan £m	Actual £m	Variance £m
BHRUT	0.0	(14.5)	(14.5)
Barts Health	0.0	(12.9)	(12.9)
East London NHSFT	0.0	1.9	1.9
Homerton	0.0	0.0	0.0
NELFT	0.0	1.4	1.4
Total NEL Providers	**0.0**	**(24.1)**	**(24.1)**
NEL ICB	(0.0)	0.0	0.0
NEL System Total	**0.0**	**(24.0)**	**(24.0)**

The ICB has reported ongoing run rate pressures in continuing healthcare (CHC) and prescribing. These have been offset in 22/23 by non-recurrent balance sheet mitigations.

There is a year-end pressure shown against BHRUT and Barts, with a surplus reported against ELFT, NELFT and the Homerton. As reported throughout the financial year the providers have faced inflationary and payroll pressures, including agency staff. Additionally, there has been slippage against efficiency plans of £37.2m.

The month 11 expected year end position was a year-end deficit of £24.5m so there has been an improvement of £0.5m against this position at year-end.

2.1.1 Risks and mitigation

The movement to a system deficit means that previously reported risks are now embedded in the financial position.

As the year-end position in 22/23 has been managed by the release of non-recurrent balance sheet mitigations this means that there is a risk moving into 23/24 as some of the pressures seen in 22/23 are recurrent and ongoing.

The work ICS partner organisations to try to mitigate the current and future financial pressures is ongoing. The ICB Chief Finance and Performance Officer has constituted a finance recovery working group across the whole of the ICS. This will review and drive forward the in-year financial position, efficiency and savings target and oversee the development of a 5 year system financial plan.

3.1 Draft Financial Statements

The draft Financial Statements for the period ended 31 March 2023 have been prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023 and subsequent NHS England guidance. The statements were reviewed by the Finance, Performance and Investment Committee and the Audit and Risk committee ahead of submission to NHS England.

The draft Financial Statements detail how £3,186,087k net expenditure for the period was spent against the £3,186,125k revenue resource limit to generate a £38k underspend. Also reported within these statements is how the ICB spent £33,473k of its running cost allowance of £33,690k.

NHS North East London ICB board

31 May 2023

Title of report	Performance Report – February 2023 period
Author	Clive Walsh Interim Director of Performance
Presented by	Henry Black, Chief Finance and Performance Officer
Contact for further information	Clive Walsh Interim Director of Performance clive.walsh2@nhs.net
Executive summary	The attached set of slides describes the performance of the overall system across seven domains of performance in February 2023. For Urgent & Emergency Care (UEC) March 2023 data is available. The total waiting list in planned care has fallen after rising over three months, and the numbers of long waiting patients continues to fall. The total waiting list and number of long waiting patients are above trajectory. The impact of medical staffing industrial action will be seen in March and April 2023. There is a revised national requirement to treat all patients waiting > 78 weeks by 30 June 2023. The number of patients waiting more than 62 days for cancer treatment continues to fall and is now close to the trajectory. Nationally, it was recognised that December 2022 was the most challenged month for emergency care flow and there has been a general trend of improvement against that low point. On 30 January 2023, a national UEC recovery plan was published, and the ICB was informed on 10 May 2023 that the system will be supported in Tier 1 (highest risk) for 2023/24. The ICB received a wide-ranging overview of UEC services at its meeting on 29 March 2023.
Action required	The Board is asked to note the report, and provide further feedback on improving the content and presentation, if required.
Previous reporting	Each of the performance domains has associated improvement activity and this is managed through system-wide Boards or collaboratives, for example, the Planned Care Board
Next steps / onward reporting	This material will form the basis of the parallel report 30 May 2023, to the NEL Finance, Performance and Investment Committee (FPIC)
Conflicts of interest	No known conflicts of interest
Strategic fit	This report aligns with the following ICS aims: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	Improving access to healthcare and the speed of treatment is likely to benefit disadvantaged groups among the local residents. The ICS is participating with NHSE-London in building in the views of London residents on UEC services.

Impact on finance, performance and quality	The locality improvement plan, arising from the Care Quality Commission (CQC) inspection of the BHRUT Emergency Department and the adjacent Urgent Treatment Centre, will be monitored through the monthly UEC Programme Board. There have been more than 10 days of industrial action affecting patients (particularly for ambulance services and medical staffing), and the mitigating actions have increased costs, and resulted in extensive cancellation of planned care patients. There has been a London-wide and local discussion on evaluation of harm.
Risks	The risks and issues are described against the relevant performance domains. The top three risks in the CPFO risk log are impacted by the activity performance across the system

1.0 Purpose of the report

1.1 This is one of a regular series of performance reports which come to each meeting of the ICB. The aim is to provide assurance to the Board with regard to the effective monitoring of performance, identification of risks to delivery and the mitigating actions put in place.

1.2 The Board is asked to note the report, and provide further feedback on improving the content and presentation.

1.3 The system's performance against the agreed activity volumes and standards has an impact on all four of the ICS' strategic aims:

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

2.0 Key messages

2.1 The total waiting list in planned care has fallen, along with the numbers of long waiting patients. The total waiting list is now above the trajectory level, as the plan was for an even more rapid reduction.

2.2 The UEC domain shows an improvement in UEC factors. Nationally, it was recognised that December was highly challenged for emergency care flow and the local improvement since then is also reflected nationally. The NE London system has been designated as Tier 1, requiring the highest of intervention and support from the national UEC team. The relationship between the Tier 1 status and the existing system oversight framework (SOF) 4 process for BHRUT has yet to be determined.

2.3 The number of patients waiting more than 62 days for cancer treatment has fallen, but remains slightly above trajectory.

3.0 Performance in February 2023 and March 2023

3.1 The attached set of slides describes the performance of the overall system across seven domains of performance in February 2023. For Urgent & Emergency Care (UEC) March 2023 data is available. The detailed description and analysis for each of the domains is included in these slides.

3.2 Following the publication of the national EUC recovery plan, an evaluation process of relative performance has been undertaken by NHSE. This has led to the designation of NE London as a Tier 1 system, requiring the highest level of support and intervention. 15% of ICBs have been assessed as falling into the Tier 1 band. Further information will be provided to the ICB on the implications of this designation when these details are available. The measures of success for UEC in the 23/24 Operational Plan will be the 4-hour standard for patient treatment in ED and the speed of transfer for patients from the ambulance service to ED care.

3.3 Several periods of industrial action have been held by ambulance and medical staff, through January to April 2023. Approximately 1,300 patient operations and 8,000 outpatient appointments have been postponed, as a result, with further loss of unbooked capacity over and above this. This represents a significant loss of volume, and will lead to a delay in reducing waiting list size and waiting times. There will be a

longer-term London-wide study into the harm resulting from these delays. In the meantime, the NE London Clinical Advisory Group (a sub-committee of the Executive Group) will produce a report on any patient harm observable within the provider services in NEL. There is a revised system plan to meet the national requirement to treat all patients waiting longer than 78 weeks by 30 June 2023. In mid-May 2023 the total number of such patients was c. 300 and a further 600 patients will need to be treated who are currently waiting 72 weeks or longer. It is anticipated that the system will be close to achieving this standard and will offer mutual aid in some specialist services.

4.0 Risks and mitigations

4.1 The risk and mitigations are described for each of the performance domains.

5.0 Conclusion

5.1 The Board is asked to receive the report for assurance purposes and to note its contents. Any further feedback on the content or the presentation of the material is welcomed by the author.

6.0 Attachments

6.1 Attached is the set of Powerpoint slides which covers the detail of each of the performance domains. An electronic copy is available to committee members and a hard copy of the slides will be available on request.

7.0 Author

7.1 Clive Walsh, Interim Director of Performance
Each of the performance domains is reported by the subject expert.

Report drafted: 18 May 2023

Planned Care Recovery & Transformation – Feb 2023

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published February-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Planned Care	Total Waiting List (volume)	✗	195,471	199,028	▼	
	Waiting List >104 Weeks (volume)	✗	0	8	▼	
	Waiting List >78 Weeks (volume)	✗	178	554	▼	
	Waiting List >52 Weeks (volume)	✗	5,593	7,880	▼	
	Clock Stop Activity (% 19/20 BAU)	✗	89.6%	89.1%	▲	
	Inpatient Elective Activity (% 19/20 BAU)	✗	103.0%	91.6%	▼	
	Consultant Led Outpatient Attendances (% 19/20 BAU)	✗	103.6%	99.3%	▲	

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

Key Headlines

- The overall NEL RTT waiting list decreased in Feb-23 to 199,028 pathways (-1,093 pathways from the Jan-23 position). The reduction driven by Barts Health (-765 pathways, across inpatient and outpatient pathways) and BHRUT (-362 pathways, driven by a reduction in outpatient pathways). The overall waiting list increased marginally at Homerton by +34 pathways, driven by an increase in outpatient pathways. The RTT waiting lists at Barts Health and Homerton remain above trajectory for the month.
- The number of patients waiting 2 or more years (>104 weeks) for their planned care was 8 in Feb-23, a decrease of - 5 pathways compared to Jan-23. The improved position at Barts Health continued in month, with 7 pathways >104 weeks reported in Feb-23. Despite, previously having 0 pathways waiting >104 weeks, BHRUT reported 1 admitted pathway waiting >104 weeks in Feb. This patient has since been treated.
- The number of patients currently waiting 18 months or more (>78 weeks) in NEL decreased in Feb-23 for the second month, following the increase seen in December, to 554 pathways (-241 pathways from the Jan-23 position), driven by Barts Health (-205 pathways) and BHRUT (-34 pathways). HUH reported 0 patients waiting >78 weeks for the month (following 2 pathways reported in Jan-23). BHRUT have forecast 0 patients waiting at end of April and May (with the exception of patient choice). Barts Health are working towards an ambition of 0 patients waiting >78 weeks by end of Jun-23 (with the exception of patient choice).
- The number of patients currently waiting 1 year or more (>52 weeks) continues to fall to 7,880 pathways in Feb-23 (-297 pathways from the Jan-23 position) due to improvements at Barts Health (across the inpatient waiting list) and BHRUT (across inpatient and outpatient waiting lists), both Trusts however, above trajectory for the month.
- In line with RTT rules a patient's RTT clock is stopped at the point of first definitive treatment, or other clinical decision not to treat, removing the patient from the live RTT waiting list. In Feb-23, the volume of clock-stops was 89.1% against 2019/20 baselines.
- Consultant led outpatient activity was at 99.3% of pre pandemic levels in Feb-23. Homerton reporting the highest level of consultant led outpatient activity at 111% (above plan) of 19/20 levels. Barts Health and BHRUT delivering 98% and 96% respectively (below plan).
- Inpatient activity in Feb-23 was 91.6% of 19/20 levels. BHRUT reporting the highest levels of activity at 97%, Barts Health delivering 91% and Homerton 85% of 19/20 levels (all three Trusts below plan).

Workstream Issues and Risks

- The number of patients continuing to wait 2 years or more (>104 weeks) at Barts Health.
- Patients continuing to wait 18 months or more (>78 weeks) at Barts Health post Mar-23.
- Impact of further Industrial Action on elective recovery and the long waiting position.
- Implications for the 2023/24 starting position and scale of challenge, in relation to long waits, levels of activity and Operating Plan requirements and trajectories.

Mitigating Actions and Next Steps

- Continued NEL and regional monitoring of the volume of patients waiting 18-months or more. Barts Health are working with hospital teams on additional schemes to support the year end position and utilisation of collaborative capacity, particularly due to the impact of ongoing industrial action. Barts Health are working towards an ambition of 0 patients >78 weeks by end of Jun-23.
- Bi-weekly assurance meetings held with NHSE region and Barts Health, to support treatment of all patients waiting 2 years and 18 months or more continue.
- Revised Barts Health Elective Recovery Board focus and governance.
- NEL wide D&Q and validation peer review across three specialties initially (Gynae, ENT and T&O) at BHRUT, Homerton and Barts Health – first peer review covering all three specialties due to take place with Homerton 10/05.
- Ongoing Trust and site productivity programmes with the aim to improve inpatient activity via improved theatre productivity and utilisation, overseen via the NEL Surgical Optimisation Group.

Governance

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

Outpatient Transformation – Feb 2023

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published February-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Outpatient Transformation	Specialist Advice (volume)	✓	15,907	19,589	▼	
	Specialist Advice (% OPFA)	✓	National Req. 16%	30.27%	▲	
	Moved or Discharged to PIFU (volume)	×	6,984	2,633	▲	
	Moved or Discharged to PIFU (% OPA)	×	National Req. 5% in Mar-23	1.21%	▲	
	Outpatient Virtual Activity (volume)	×	54,997	41,429	▼	
	Outpatient Virtual Activity (%)	×	National Req. 25%	19.09%	▼	

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

Key Headlines

- The volume of GP specialist advice requests (incl. advice and guidance, referral assessment and triage with the overarching aim to reduce non-value adding outpatient appointments) received and responded to by the three NEL Trusts was 30.27% of all first outpatient appointments in Feb-23, further increase YTD and remaining well above the 16% Operating Plan ask (both A&G requests and outpatient attendances are down overall marginally in Feb compared to Jan, likely due to it being a shorter month).
- 2,633 patient pathways were moved or discharged to PIFU (meaning patients are able to self-initiate their own follow-up with the intention to reduce non-value adding follow-up appointments / booking of appointments by default) in Feb-23, equating to 1.21% of all outpatient attendances. PIFU volumes (actual) and rates have declined at Barts Health over the last 2-months, the Barts Health Outpatient Transformation programme plans to further roll-out delivery of PIFU (alongside other interventions) during 23/24. PIFU activity at BHRUT continues to progress. Homerton had a particularly strong month, with the highest volume and rate of patients moved to PIFU YTD, based on an already strong position comparatively at 4.5%.
- 19.09% of all outpatient appointments in NEL were delivered virtually (via video/telephone/non-face-to-face) in Feb-23 (Barts Health 13%; BHRUT 23% and HUH 32%). While the trend shows a downward trajectory this is based on relatively small movements overall - the volume of appointments delivered virtually remains fairly consistent, ranging from circa 21%-19% at NEL level.

Workstream Issues and Risks

- Volume of patients awaiting outpatient appointments and treatment.
- Implications for the 2023/24 starting position and scale of challenge, in relation to long waits, levels of activity and Operating Plan requirements and trajectories
- System functionality and interoperability to support and expedite key initiatives and interventions e.g. PIFU
- Resource implications and job planning to support and expedite key initiatives and interventions e.g. GIRFT and A&G/R
- Elective Recovery Fund (ERF), incentivisation and funding structure for 23/24 (follow-up activity above 75% of 19/20 levels will not be funded in 23/24 and no national incentivisation for A&G/R)

Mitigating Actions and Next Steps

- NEL modelling supported by NHSE region to understand opportunity for FUP reduction in line with national GIRFT guidance across specific pathways within T&O, General Surgery, Ophthalmology and Gynaecology.
- 'Waiting Well NEL' website – expected launch May-23
- Work to provide patients with GPs with more meaningful information re waiting times via consistent and visible reporting of time to first outpatient appointment.
- Ongoing roll-out of 'Advice and Refer' pilots across NEL (whereby all GP referrals receive advice and guidance prior to referral with the aim to reduce referrals, join up working, and 2-way support education) – NEL level 'weighting' exercise by speciality completed to help inform decision making.
- Plans to establish a clinically led outpatient transformation working group to help drive key programmes of work e.g. A&R, GIRFT, etc., to be taken forward
- Ongoing targeted reduction to improve patient DNA rates (e.g. the 'outpatient reminder service' in BHRUT).
- Outputs of NEL wide outpatient transformation workshop 02/02 focussing on follow-up reduction being progressed
- NEL wide Dermatology and ENT task and finish groups established and programmes of work agreed
- Roll-out of national GIRFT specialty outpatient guidance (clinically-led specialty outpatient guidance, developed for clinicians and operational teams) by individual Trust outpatient transformation programmes, supported at NEL level.

Governance

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

Diagnostics – Feb 2023

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published February-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Diagnostics	Total Waiting List (volume)	N/A	N/A	55,084	▲	
	Waiting List >6 Weeks (volume)	N/A	N/A	7,877	▼	
	Performance (%)	N/A	N/A	14%	▼	

KEY

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

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

Key Headlines

- In Feb-23, there were 55,084 patients waiting for a diagnostics test in NEL (+3,076 compared to Jan-23) position.
- The number of patients waiting longer than 6 weeks for a test saw significant reduction to 7,877 (- 1,804 to Jan-23) driven by improvements across all three Providers and performance of 14.30% against the DM01 Target of 1%.
- NEL continues to report the highest volume of patients waiting an imaging investigation in London. The number of patients waiting over 6 weeks is greatest at Barts Health, mainly driven by waits for Non-Obstetric Ultrasound (NOUS), MRI and CT albeit improvements noted in the latest month.
- Colonoscopy has the greatest increase in the no. of patients waiting over 6-weeks (125 patients, +103 more than Jan-23).
- The majority of patients waiting at HUH are waiting less than 6 weeks; with the challenged modalities being MRI, Non-Obstetric Ultrasound and Echocardiogram. MRI downtime and increased Non-Obstetric Ultrasound demand are key drivers to overall position.
- The number of patients waiting over 6-weeks at BHRUT continues to reduce overall, MRI has the greatest backlog of all tests and the Trust has forecast Mar-23 performance to be <5%.
- Staff and patient related sickness are key drivers to both HUH and Bart's Health's monthly DM01 position.
- Latest weekly unvalidated data (w.e. 23 Apr-23) indicates NEL W/L at 50,917 and backlog position at 10,419. It is important to note the impact of Industrial action on this position. (Patient and clinic cancellations).

Workstream Issues and Risks

- Increasing demand for NOUS; pressure from A&E and inpatiemt to improve turnaround times
- MRI and Non-Obstetric Ultrasound recovery of the > 6-week waiting position still remains fragile at HUH.
- Staffing resource (sickness) raised as operational risk at both HUH (radiography, administrative staff and sonographers) and Barts Health (MRI and Non-Obstetric Ultrasound at both RLH and St Barts) – ongoing risk to recovery of overall backlog in subsequent months.
- Collaborative capacity for NOUS paused and vacant capacity in diaries for MRI/CT
- Reduced OOH capacity for waiting lists (W/L) for MRI for April 23 due to bank rates

Mitigating Actions and Next Steps

- Reduced MRI very long waiters, with focus on ensuring all patients waiting > 26 waits are reviewed and/ or have a date, managed via the local recovery programme and escalate where necessary.
- Collaborative Capacity is being provided between hospital teams including at Barking, Newham, WX and Homerton hospitals.
- NEL Hospital teams have developed operational plans for 23/24 Financial Year which will be monitored in year.
- NEL to agree operational sustainability approach for the system and develop the productivity matrix.
- Coordinate NIDC returns, agree scope and review contracts with third parties and finalise workforce numbers

Governance

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

Cancer – Feb 2023

SRO:	Femi Odewale	RAG	AMBER

	Metric	Latest Published February-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Cancer	31 Day Treated (volume)	✗	537	456	▼	
	Waiting List >62 Days (volume)	✗	510	538	▼	
	Waiting List >104 Days (volume)	N/A	N/A	115	▼	
	Faster Diagnosis Standard (%)	✗	75.66%	74.85%	▲	

KEY

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

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

Workstream Issues and Risks

- Barts has moved into a Tier position (organisations with a backlog above their fair shares requirement)
- Industrial strikes had a greater impact on Barts within our system as Staff were deployed to support operational pressures.

Governance

- NEL ICB Cancer Alliance and Performance have regular deep-dives and bi-weekly meetings with NEL Acute Providers about their recovery action plans (with focus on challenged tumour sites).
- NEL Cancer escalations are managed through the NEL Cancer Board which is governed by the APC Board which then feeds into the ICB.
- The NEL Performance team also have regular meetings with the Acute Providers around constitutional standard performance and progress against Op Plan Trajectories.

Key Headlines

- NEL cancer performance overall remains amongst the best in the country when compared to other systems in England and produced the strongest performance when compared to other London ICB's this month.
- In Feb-23, NEL delivered five of the nine cancer waiting time (CWT) constitutional standards for patients.
- 2 week-wait was compliant this month but the 62 days urgent GP referral still requires improvement. Remedial plans are in place and on track to improve albeit histopathology remains a key risk to delivery across NEL.
- Only Barts achieved the 2ww Breast Symptomatic standard in Feb-23. NEL Position was driven by fewer treatments owing to the impact of the industrial action coupled and workforce capacity at Barts Health and HUH. Plans are in place to improve this position in subsequent months.
- NEL did not achieve the Faster Diagnosis Standard (FDS) in Feb-23 albeit both Barts and HUH achieved the 75% threshold. Diagnostic delays on Lower GI and Gynae pathways are key drivers as is overall Dermatology demand. Workforce challenges in Head and Neck and Urology at Barts Health have also contributed to the overall position. Mitigating actions are in place and performance improvement is expected going forward.
- NEL has made great progress in reducing the 62-day backlog in recent months. As at **23rd Apr-23**, NEL had a total of (610 Patients) waiting >62 Days representing 7.7% of the total PTL.

Mitigating Actions and Next Steps

- NEL has identified the challenged pathways and through the Cancer Alliance we will work with providers to take a targeted pathway approach in urology (access to MRI & TP biopsy), H&N (outpatient capacity and ENT calculator), LGI (appropriate escalation of pathology turnaround times and endoscopy capacity), and Skin (tele-dermatology with one stop excision following triage).
- The Cancer Alliance will continue working with providers to implement and strengthen best practice times pathway. With a focus on those performing below the England Faster Diagnosis Standard.
- The use of the NSS RDC is being used to improve the overall demand for patients with a FIT <10 as well as implementing the national guidance recently signed off by the London CAG
- Two out of three providers in NEL are piloting tele-dermatology models for 2ww referrals and the key focus in 23/24 will be to expand, evaluate and sustain these pathways across the region.
- NEL Cancer Alliance are funding a senior programme manager to support the trust and networks identify ways in which the backlog issues within the acute can be resolved. The PM will explore notions such as flagging urgent samples, maximising the existing workforce by centralising processes identifying technological advances to support the improvement.
- We are also evaluating innovative ways to improve radiology reporting capacity – (consideration of networked roles and technology allows for remote reporting
- The NEL Cancer Alliance and CDC work programmes are collaborating to ensure that diagnostic capacity is identified and safeguarded across its two current sites (MEH, Barking) but also in developing its 3rd site (Ilford) to ensure we have capacity to meet the anticipated 25% increase in demand and provide further capacity within the hospital sites to help attain the Best Practice Timed Pathways for cancer tumour sites.

Urgent and Emergency Care – Mar 2023

SRO:	Clive Walsh	RAG	RED

	Metric	Latest Published March-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
UEC	Ambulance Handovers ≥ 60 Min (volume)	⊗	National Req. ZERO	1,195	▲	
	12-hour Trolley waits (volume)	⊗	National Req. ZERO	1,602	▲	
	Total A&E Attendances (volume)	N/A	N/A	82,673	▲	
	A&E 4-Hour Performance All Type (%)	⊗	National Req. 95%	65.62%	▲	
	A&E 4-Hour Performance Type 1 (%)	⊗	National Req. 95%	54.36%	▲	
	Total A&E Admissions (volume)	N/A	N/A	11,526	▲	

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

Key Headlines

- In Mar-23, 1,195 arrivals by ambulance at NEL emergency departments (EDs) took more than 1-hour to be transferred from London Ambulance Service care (up 124 on previous month driven in totality by BHRUT). 83% of all handovers took place within 60 min (Barts 87%, BHRUT 70%, HUH 100%), a slightly improved position on the previous month driven by Barts.
- 23% of arrivals by ambulance were handed over from London Ambulance service care within 15 min of arrival at ED (Barts 19%, BHRUT 8%, HUH 69%), which is similar overall to the position in Feb-23 for this metric.
- 52% of arrivals by ambulance were handed over within 30 mins of arrival at ED (Barts 55%, BHRUT 30%, HUH 95%), down from 53% in Feb-23.
- In Mar-23, 66% of all patients were seen within 4-hours of arrival at ED (63% in Febn-23), BHRUT remains the most challenged. 54% of Type 1 patients (often considered the most Acute patients) were seen within 4-hours, up from 52% in Feb-23.
- The national UEC recovery plan was published on 30 Jan 2022 and will form the basis of the 23/24 plan (https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/)

Workstream Issues and Risks

- A combination of Industrial Action, staffing shortages and increased acuity of patients attending EDs continue present risk to the acute site's ability to take handovers from Ambulance Crews, which saw an increase in numbers waiting >60 mins in this period.
- There are still overly high numbers of Medically Optimised patients occupying beds, which when combined with poor discharges, has a detrimental impact on flow and causes delays
- There was a noticeable improvement in A&E 4hr performance overall and for Type 1.
- MH capacity proving to be a challenge and placing additional constraints on the ability for EDs to maintain flow due to cubicles being 'out of action' when occupied for extended periods by MH patients,

Mitigating Actions and Next Steps

- Continued close working with LAS to review practices and SOPs across NEL acute sites for Ambulance Handovers – consideration is being given to developing an area at RLH for LAS Cohorting.
- Continued promotion of the REACH service to manage appropriateness of Ambulance Conveyances, where clinically sensible to do so – still only very low numbers of calls referred.
- Close working with Place Leads to examine progress of Virtual Ward capacity along with Community Beds and Domiciliary Care availability vs demand for discharges needing care packages.

Governance

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

Health Services in the Community – Feb/Mar 2023

SRO:	Charlotte Pomery and Jo Moss	RAG	AMBER

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

	Metric	Latest Published			
		Achievement	Trajectory	Actual	Change from prev. period
Health Services in the Community	Appointments in General Practice - Mar-23	✗	1,122,359	1,023,280	▲
	Learning disability registers and annual health checks delivered by GPs - Q4 22/23	✓	75.00%	88.00%	▲
	Personal Health Budgets - Q4 22/23	✗	4,311	4,195	▼
	2-hour Urgent Community Response (UCR) care contacts - Count of 2-hour UCR first care contacts delivered within reporting quarter - Q3 22/23	✓	1,667	13,885	▲
	Community services waiting list-Number of patients waiting at a point in time aggregated for a) in scope CYP and b) in scope Adult services - Q3 22/23	✓	31,497	16,358	▼
	Number of CYP (0-17 years) on community waiting lists - Q3 22/23	✓	11,207	5,632	▼
	Number of Adults (18+ years) on community waiting lists - Q3 22/23	✓	20,290	10,726	▼

Key Headlines

Primary Care

- The actual number of booked appointments increased to match trajectory during March. During March 43% of appointments were seen on the same day and 78% were within 7 days. 66% were face-to-face and 33% over the phone. 57% of these appointments were with a GP and 43% with another member of practice staff like a nurse. This is in line with the London average. We are viewing access to general practice alongside a range of measures that capture both the technical as well as the perceived quality elements of good access. We are developing a set of principles to support place based teams to streamline patient access to the most appropriate type of appointment and advice with clear signposting for health care professionals and residents to ensure they are directed to the full range of services available.
- There is a focus in the GP contract 23/24 on improving access and patient experience. GP Capacity and Improvement payments will help practices to improve patient experience of contacting the practice, manage demand and capacity and ensure accurate recording in appointment books.

Learning disability

- NEL exceeded the target of 75% of people on the LD register having their Annual Health Check, achieving 88% (this % will be reconciled and is likely to increase over the next few weeks).
- A stretch target was also set by NHS England of 75% of the estimated LD population receiving an AHC; NEL currently stands at 74.2% but this is still likely to be achieved after reconciliation.

Personal Health Budgets

- NHS North East London is currently ahead of its trajectory for personal health budgets (PHBs) and has an established programme of work focussing on supporting the uptake of PHBs for the right to have areas and covering the main NEL priorities: mental health, long term conditions and CYP.

2 hour UCR

- UCR – Based on the published data: At NEL Level the UCR 2 hours standard has been achieved (81% against 70% target). ELFT (98%) and NELFT (78%) and Homerton (93%) against 70% target. Based on the local data from providers: All providers have achieved above 70% national target.

Community Waiting List

- Community Waiting List – Data submissions to NHSE have time lag issue. NEL will aim to meet trajectories it set at the start of 22/23 by end of March/Q4. Forward Plan in place to ensure NEL regularly monitors against trajectories monthly from the main service providers Barts, ELFT, NELFT, Accelerate, Homerton.

Workstream Issues and Risks

Primary Care

- The general practice appointments (GPAD) data has significant data quality issues, with a proportion of activity 'unmapped' or 'inconsistently mapped' for instance 14% of appointments in NEL are uncategorised.
- The data set available shows a limited view of appointment information and does not show appointment status e.g. attended or DNA (non-attended appointments).

Learning disability

- In previous years the majority of Annual Health Checks have been delivered in Q4, which means that this pattern will continue and a high percentage of AHCs will need to be delivered in Q4. This demand has been met in previous years but will be monitored by primary care and LDA leads.

2 hour UCR

- UCR - NEL consistently meeting 2hr UCR Target and is working on the delivery of pull pilot to increase case numbers from 111/999, meeting 9 matrix standards
- UCR - Last Referral times are variable across London. NHSE region have asked all providers to continue to update and ensure details on the regional matrix true reflect closing times

Community Waiting List

- Waiting List – Delayed metrics; NEL providers make monthly submission into NHSE Community Services Data Set (CSDS) however this submission has a time delay like UCR in reflecting this data back to ICBs. CSDS publications are retrospective (two-three months delay).
- Waiting List – Lengths over 52 weeks in CYP services should be a particular focus. ELFT speech and language and looked after children waits to be looked at. Whilst there is no target set nationally for reductions NEL should get a head-start before 23/24 to make wait times come under 52 weeks
- Waiting List – Increases are due to Workforce recruitment & availability, increased demand and referrals

Mitigating Actions and Next Steps

Primary Care

- The NEL Data Quality Accreditation scheme has been rolled out across all practices which will improve coding.
- Using digital technology such as Edenbridge APEX which has been rolled out across NEL in order to get the most accurate appointments and clinical data directly from practice clinical systems. Completed episode data will be included into the forward plan.
- Developing an quality improvement approach to support general practice understand capacity and demand.
- Each PCN will develop a Capacity and Access Improvement Plans to work towards improving patient experience of contacting the practice, manage demand and capacity and ensure accurate recording in appointment books.

Learning disability

- NEL are pleased to have achieved the national target for learning disability annual health checks. In 2023/24 we will be focusing on improving the quality of AHCs and also piloting the new annual health check for autistic people in City & Hackney.

2 hour UCR

- NEL will mobilise a new UCR pilot to enable more cases to be pulled into UCR services from LAS electronically.
- Work will also get underway to better understand the impact of above trajectory performance to deliver 2 hour UCR on the rest of the system.

Community Waiting List

- Waiting List - NEL will have in place monthly data to enable the system to see individual provider positions
- Waiting List – Forward Plan in place to ensure NEL meets trajectories from main providers - Barts, ELFT, NELFT, Accelerate, Homerton – by Q4 and 52 week target by early Q1 23/24 FY.
- Waiting List – Collaborative to do deep dive on waiting list reduction initiatives in 23/24 to better understand and learn collectively what the issues are – workforce transformation initiatives could be looked at to help reduce particularly long waits (reconfiguring staff focus, digital options etc.)
- Waiting List – agreement to focus on strategic work across the system, linked in to Place Partnerships, on developing a framework for a system response to addressing communications needs, achieving improved outcomes whilst reducing the waiting lists for speech and language therapy given workforce constraints

Governance

Primary Care

- Operating plan monitoring. Monthly data provided from national GPAD reporting
- Primary Care Collaborative, GP Provider Group exploration of issues and sharing of best practice through a series of lunchtime webinars. Collaboration with Pharmacy Provider Group and close working with urgent care colleagues.

Learning disability

- Oversight of Annual Health Checks is provided at NEL level by the Learning Disabilities and Autism Transformation Board and the MHLDA Strategic Board.

2 **hour UCR and Community Waiting List**

- NEL Community Based Care Delivery Group (delivery), Community Collaborative Executive (Oversight) and Community Collaborative (system assurance)

Mental Health – Feb 2022

SRO:	Dan Burningham	RAG	AMBER

	Metric	Latest Published				
		Feb-23	*Trajectory*	*Actual*	Change from prev. Month	6 Month Trend
Mental Health	IAPT Access (Volume)	✓	*4,701*	*4,770*	▼	
	Dementia Diagnosis (Rate)	×	*66.70%*	*59.24%*	▲	
	SMI Physical Health Checks (Performance)	✓	*60.00%*	*64.79%*	▲	
	Perinatal (Rate)	×	*8.48%*	*7.41%*	▲	
	CYP Access (Volume)	×	*24,322*	*22,245*	▲	
	Early Intervention in Psychosis (EIP)	✓	*60.00%*	*74.19%*	↔	
	CYP Eating Disorders Urgent Referral (Performance)	✓	*95.00%*	*97.67%*	N/A	
	CYP Eating Disorders Routine Referral (Performance)	×	*95.00%*	*90.44%*	N/A	

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

Key Headlines

- A number of measures of service performance have improved when compared with the end of 2021/22. However, the plans set for the end of 2022/23 remain at some risk, as the rate of improvement needs to increase substantially.
- Services of note are; Improving Access to Psychological Therapies (IAPT, Talking Therapies), Children and Young People's (CYP) mental health access, Perinatal mental health support to women, Dementia diagnosis, and Physical Health Checks for people with Serious Mental Illness (SMI).
- SMI Physical Health checks have achieved the 60% target for the first time in 2022/23, with almost all boroughs achieving this target.
- The NEL position compared with other London systems is mixed. CYP access and SMI health checks are performing well against the London position, however Dementia diagnosis performance is challenged compared to other London regions.

Workstream Issues and Risks

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

Mitigating Actions and Next Steps

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

Governance

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

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Governance Handbook Amendments
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery, Chief Participation and Place Officer
Contact for further information	annemarie.keliris@nhs.net
Executive summary	At its 30 November meeting, the Board agreed the updated Governance Handbook, which sets out the governance arrangements for the organisation, including terms of reference (ToRs) and governance policies. Since then there have been further updates to committee ToRs which include recommendations made in a recent internal audit review on governance and risk. There has also been further work to develop the ToR of sub-committees at place which links to the mutual accountability framework. The Audit and Risk Committee recently approved updated governance policies including: • Freedom to speak up policy – the policy has been updated to include changes to contact details of the guardian service given we have now commissioned an independent organisation to provide this service. • Standards of business conduct and conflicts of interest policy - the policy has been updated to include changes to guidance on receiving gifts, training and contact details. These policies are also updated within the governance handbook. The Barking and Dagenham Borough Partnership have developed proposals to hold the ICB sub-committee and Health and Wellbeing Board (HWB) as a committee in common from June 2023. Partners from the ICB and London Borough of Barking and Dagenham have been working with legal advisors to develop a framework to describe the arrangement. A closer alignment of the HWB and the ICB sub-committee will streamline the current governance arrangements; speed up decision making, improve alignment of actions on priorities and in doing so will improve services through greater collaboration and

	reduction in duplication. (Further details attached at appendix A). Further work is ongoing on the development of joint committee arrangements of the collaboratives – an update on this will be presented to the next board meeting. The delegation agreement for dentistry, optometry and pharmacy services is now included in the handbook following the agreement at the last board to approve the delegation agreement with NHS England. The scheme of reservation and delegation (SoRD) has also been updated to reflect these changes. The updated handbook is available here. Each year, committee members of the board and committees are asked through a survey to share their views on the effectiveness of their board/committees, reflecting on what went well and what could be improved. This is to inform future development of the board/committee and a summary of the results are included in the annual report. Given the ICB was established part way through the financial year, with nine months of board/committee operations from July to year end, these results are a more limited snapshot than usual, but still provide useful feedback to consider in terms of what to build on, change and develop for the new financial year. The key themes from these surveys will be presented to the next board to consider and agree recommendations to take on learning to develop and strengthen governance for the second year of the ICB.
Action required	To agree: • The proposed Barking and Dagenham committee in common arrangement. • The updated Governance Handbook
Previous reporting	ICB Board and each ICB Committee and Sub-committee.
Next steps/onward reporting	The Governance Handbook will then be further reviewed on an annual basis.
Conflicts of interest	Not applicable

Strategic fit	Links to overall design and governance of the ICB and integrated care system as established on 1 July 2022 and to support all four core objectives: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The new inclusive governance is designed to support the new organisation and system to make improvements to access, experience and outcomes for local people - with an overall focus on tackling health inequalities.
Impact on finance, performance and quality	There are no immediate financial implications.
Risks	There are no immediate risks identified.

Barking and Dagenham Place Based Governance Proposals

Background[1]

1 From 1 July 2022 the Board of the NHS North East London Integrated Care Board ('**ICB**') established the B&D Sub-Committee ('the **Place ICB Sub-committee**'), to work in tandem with the B&D Partnership Board, thereby forming the B&D Place-Based Partnership. Under these arrangements, which are described in the Place-Based Partnership's suite of terms of reference:

- The **B&D Partnership Board** is the collective governance vehicle established by the ICS partner organisations to collaborate on strategic policy matters and oversee joint programmes of work relevant to Place.
- Where a formal decision needs to be taken which relates solely to a function of the ICB, then this is to be taken by the **Place ICB Sub-committee**.
- The B&D Partnership Board and Place ICB Sub-committee's terms of reference align and there is a significant overlap in their membership, which enables the two structures to meet together efficiently within the forum of a single meeting.
- The Place-Based Partnership is expected to collaborate with the Barking & Dagenham Health and Wellbeing Board ('**HWB**') but the HWB was not a formal part of the Place-Based Partnership.

2 Through the arrangements described below, the HWB will now become an essential part of the Place-Based Partnership. This document describes interim arrangements for a committees-in-common arrangement between the HWB and the Place ICB Sub-committee. The partners at Place will keep these arrangements under active review, and work towards formalising their governance through updated terms of reference in due course.

Arrangements from 26 June 2023

3 From 26 June 2023, the following arrangements will apply:

Governance structures

(a) The HWB and the Place ICB Sub-committee will meet as committees-in-common, in order to promote consistent decisions being taken between organisations at Place. Decisions taken by the London Borough of Barking and Dagenham ('**LBBD**') and the ICB within the forum of the aligned meeting can be taken simultaneously but they will remain separate decisions that

[1] Fuller background to the new arrangements is described in Annex A.

each organisation is accountable for.

(b) The B&D Partnership Board will be disestablished. However, the vision, mission and values explained in the B&D Partnership Board's terms of reference, and as far as possible its role and responsibilities, will be fulfilled through the aligned meetings of the committees in common. Those aligned meetings will be the primary governance mechanism for collaborating on strategic policy matters and overseeing joint programmes of work relating to health and social care at Place.

(c) Other ICS partners[2] may take decisions relating to statutory functions at meetings of the aligned structures through individuals having delegated authority from their organisation, as reflected in the organisation's own internal governance (e.g. schemes of delegation).

Membership

To facilitate its broader work, the HWB's membership will be expanded to include the following additional non-voting members who are also members of the Partnership Board.

- Chief Operating Officer (Together First CIC, B&D GP Federation)
- Primary Care Network Director (North)
- Primary Care Network Director (North West)
- Primary Care Network Director (New West)
- Primary Care Network Director (East)
- Primary Care Network Director (East One)
- Primary Care Network Director (West One)
- NEL Local Pharmaceutical Committee Representative
- NEL Local Dental Committee Representative
- Director Care Provider Voice

(d) As non-voting members of the HWB, the individuals fulfilling these roles will need to comply with LBBD's requirements for members of its committees (e.g. as to declarations of interests, requirements for training, and adherence to LBBD's code of conduct).

(e) The Place ICB Sub-committee's membership will remain as set out in its terms of reference, except that the Chair of the HWB will also be the sole

[2] (e.g. NHS Trusts and Foundation Trusts)

chair of the Place ICB Sub-committee. A deputy chair will be appointed from the membership.

Participation

(f) Any member or standing participant of the HWB, who is not a member of the Place ICB Sub-committee, will have a standing invitation to attend meetings of the Place ICB Sub-committee when it meets together with the HWB.

(g) Where appropriate, standing invitees will be permitted to contribute to discussions at meetings to help inform decision-making. This is, however, subject to any specific legal restrictions applying to the functions being exercised or to partner organisations, and subject to conflict of interest management.

Administration of meetings

(h) Under these new arrangements, the HWB and Place ICB Sub-committee will normally meet together, as part of an aligned meeting of the Place-Based Partnership. Ordinarily, such meetings will be bi-monthly, with a minimum of five meetings each year.

(i) Although either governance structure may meet on its own at the discretion of the Chair, it is expected that such circumstances would be rare. Such circumstances might include, for example, where agenda items do not require a statutory decision of the Place ICB Sub-committee.

(j) It is recognised that the ICB and LBBD operate under different legal frameworks, and work will need to be undertaken to find the most efficient ways to lawfully host and manage meetings. While the updated governance beds in, the arrangements for governance support and agenda planning will be developed by the ICB's Head of Governance and LBBD's Head of Governance & Electoral Services, who will cooperate to devise processes which:

- Best support closely aligned meetings and integrated decision-making;
- Comply with the respective legal, constitutional and policy frameworks which apply to the local authority and ICB;
- Reflect, as far as possible, the HWB and Place ICB's Sub-committee's existing terms of reference.

The Chair of the HWB, who will also be the Chair of the Place ICB Sub-committee, will be responsible for approving the arrangements for each meeting and for approving agendas.

(k) Management of conflicts of interest will remain essential to the operation of the Place-Based Partnership and will continue to be manged consistently with partner organisations' respective statutory duties and applicable national guidance.

(l) All those who are members or participating in a meeting of the HWB or Place ICB Sub-committee shall continue to 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.

Development of aligned terms of reference

(m) The arrangements described above are intended to enable substantive decisions around health and social care to be taken by statutory ICS partners in the forum of a single meeting, in an aligned way – and to do so soon, without any substantive governance amendments being required.

(n) They will also provide an opportunity for the ICS partner organisations operating at Place to continue to develop and embed their arrangements for integrated working. It is expected that the partner organisations will further formalise their arrangements through an updated suite of aligned terms of reference, that describes how the aligned structures will operate. A working group will be established for this purpose and will report periodically to the HWB and Place ICB Sub-committee.

Review

(o) The Place-Based Partnership arrangements will be kept under active review, to consider how the governance is enabling the partners to discharge their responsibilities, deliver their objectives and work efficiently for the benefit of B&D residents. In any case, the arrangements will be reviewed within six months.

(p) Any learning which may support arrangements in NEL's other places will be shared with the ICB's Population Health & Integration Committee.

(q) Before it takes effect, this document and the arrangements described therein shall be approved by the Board of the ICB and at the first meeting of the committee in common.

Annex A - Further background

Place-Based Partnership

1 Partners across the Integrated Care System ('**ICS**') undertook a piece of work in advance of the establishment of the NHS North East London Integrated Care Board ('**ICB**') on 1st July 2022 to determine the form and governance of the seven Place-Based Partnerships in North East London ('**NEL**'). The intention for Place governance in year one was to make use of the new flexibilities introduced by the Health and Care Act 2022 to establish a governance mechanism that would enable:

- more formal integrated ways of working across the ICS, within its seven Places; and
- the lawful and efficient delegation of functions based on the principles of subsidiarity.

2 It was important to ensure that the governance arrangements enabled an "evolutionary" approach where Places could take on increasing responsibility for aspects of the ICB's work over time, and of other partners' work as national policy around health and social care integration develops. A guiding principle recommended by the principal guidance[3] on the establishment of Place-Based Partnerships was to 'build by doing.'

3 It was agreed that the preferred option from 1 July 2022 would be for the Board of the ICB to establish the B&D Sub-committee ('the **Place ICB Sub-committee**'), to work in tandem with the B&D Partnership Board, thereby forming the B&D Place-Based Partnership. A similar approach was adopted in each of NEL's seven Places.

4 Under these arrangements, which are described in the Place-Based Partnership's suite of terms of reference:

- The **B&D Partnership Board** is the collective governance vehicle[4] established by the ICS partner organisations who operate in the borough to collaborate on strategic policy matters and oversee joint programmes of work relevant to Place.
- Where a formal decision needs to be taken which relates solely to a function of the ICB, then this is to be taken by the **Place ICB Sub-Committee**.

[3] NHS England and LGA guidance: *Thriving Places* (September 2021)
[4] The B&D Partnership Board was established as a collaborative forum, rather than a committee or sub-committee of any one organisation.

- The B&D Partnership Board and Place ICB Sub-Committee's terms of reference align and there is a significant overlap in their membership, which enables them to meet together efficiently within the forum of a single meeting.
- Other ICS partners may take decisions at meetings of the B&D Partnership Board through individuals on the board having delegated authority from their organisation; or matters may need to be referred to other governance structures established by a statutory organisation where a decision can be taken.

Role of the Health and Wellbeing Board

5 In the case of decisions to be taken by the London Borough of Barking and Dagenham ('**LBBD**') which is a statutory partner in the Place arrangements, some decisions (depending on what they are) may need to be referred to the B&D Health and Wellbeing Board ('**HWB**'), which is a committee of LBBD.

6 The HWB's current terms of reference are contained in Part 2, Chapter 7 of LBBD's Constitution. The HWB performs the role given to it under statute but, in some respects, also has a broader decision-making role facilitated by delegation from the local authority (e.g. approval of certain contracts and in relation to Healthwatch).

7 Given the important and longstanding role of the HWB in the borough, the Place-Based Partnership arrangements for year one enabled and emphasised strong links and collaboration with the HWB. For example, through:

- An overlap in membership (including aspects of chairing);
- By enabling the HWB to meet with the Partnership Board and Place ICB Sub-Committee on occasion; and
- By ensuring that plans developed by the Place-Based Partnership appropriately reflect the HWB's work.

However, under the arrangements, the HWB performed more of a 'critical friend' and advisory role: In year one, the HWB was not itself a formal part of the Place-Based Partnership.

8 Through the new arrangements described in the main body of this document, the ICS partners at Place are now seeking to streamline their governance and give the HWB a central role as part of the Place-Based Partnership.

9 The governance arrangements will continue to evolve: It is expected that a key item of work for the Place-Based Partnership will be the future of its governance and exploring how further integration can be achieved most efficiently for the benefit of B&D residents.

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Board Assurance Framework
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery, Chief Participation and Place Officer
Contact for further information	Annemarie.keliris@nhs.net
Executive summary	The paper outlines progress to date and presents the updated Board Assurance Framework (BAF) which captures the highest risks to meeting the integrated care system (ICS) aims, our purpose and four priorities. The BAF has been refined and updated following review of the Chief Officer portfolio risk registers. This update also includes the detailed templates for the new risks agreed at the last meeting which include: • Mutual accountability for commitments • Digital and estates • Anti-racist commitment • Being outward looking The last Audit and Risk Committee also considered the BAF and welcomed the progress made, particularly the inclusion of digital and estates risks. The current key risks on the BAF relate to: • Collaborative working across partners • Wider determinants of health/environment • Quality and safety of care • Delivery against control total and operating plan • Workforce • Population growth • Mutual accountability for commitments • Digital and estates • Anti-racist commitment • Being outward looking
Action required	To consider and note the updated Board Assurance Framework.
Previous reporting	ICB executive management team
Next steps/ onward reporting	• Audit and Risk Committee for assurance. • ICB and ICS executive management team to review the corporate risk register in June. • Board to receive updated BAF in July 2023

Conflicts of interest	N/A
Strategic fit	Implementing the risk strategy and policy for the ICB will support achievement of the ICB's corporate objectives through managing risks to delivery. It relates to all ICS aims: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The paper sets out key risks within the ICB and system in order to achieve our aims for the health and wellbeing of our population.
Impact on finance, performance and quality	Relates to achievement of our corporate objectives on these matters.
Risks	This report relates specifically to risk. The key risk in relation to this process is ensuring that we retain high levels of delegation but ensure a joined-up approach to ensure proper management and oversight of risk both locally and NEL wide.

1.0 Background

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

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

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

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

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

The Board discussed the ICB objectives at its last meeting, the Chair and Chief Executive will be working to finalise these before the next board meeting.

2.0 Risk appetite

2.1 Risk appetite levels have been identified for each risk in line with the grading on the final page of the attached Board Assurance Framework.

3.0 Process for escalation

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

4.0 Progress to date

4.1 The BAF has been updated including the templates for the new risks agreed at the last meeting.

5.0 Risks on the BAF

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

- There is a risk that ICS partners do not work together and with local people and communities in collaborative and strengths-based ways and so cannot deliver on our

ICS purpose, aims and priorities. This could limit impact on improving the health and wellbeing of local people and reducing health inequalities.

- There is a risk that quality and safe care will be adversely affected, reflected in increasing inequalities, poorer outcomes and service failures, when we as a system do not seek to understand and prioritise the experience of local people and to act compassionately and collaboratively with them in response.

- There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents, thereby increasing health inequalities, poorer outcomes and service failures. This could also impact the ability to improve existing services and drive innovation, which in turn could lead to intervention from regulators such as the CQC.

- There is a risk that the failure to work together to produce and implement a coherent, whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support the wellbeing of our diverse workforce and deliver the range of services needed by local people, adversely impacting on their health and wellbeing.

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

- There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.

- There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation; and social networks and connections.

- There is a risk that specific populations may be adversely affected if the commitment to being an anti-racist system focussed on equality, diversity and inclusion, is not met. Effects could include poorer quality of care, outcomes and employment opportunities.

- There is a risk that as the ICB and partners focus on our system and financial challenges, that we become more inward focused and limit our opportunities to work with and influence wider partners across London impacting our ability to improve the health and wellbeing outcomes of local people and communities

- There is a risk that we are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population, due to underinvestment and

limited options to secure investment. This could impact on our ability to deliver modern and safe care.

- There is a risk that if ICS partners do not share mutual accountability for the delivery of current and future operating plans and constitutional standards, this could result in clinical variation and negatively impact on quality and performance improvement. In turn, this could lead to poorer experience and outcomes for service users.

6.0 Next steps

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

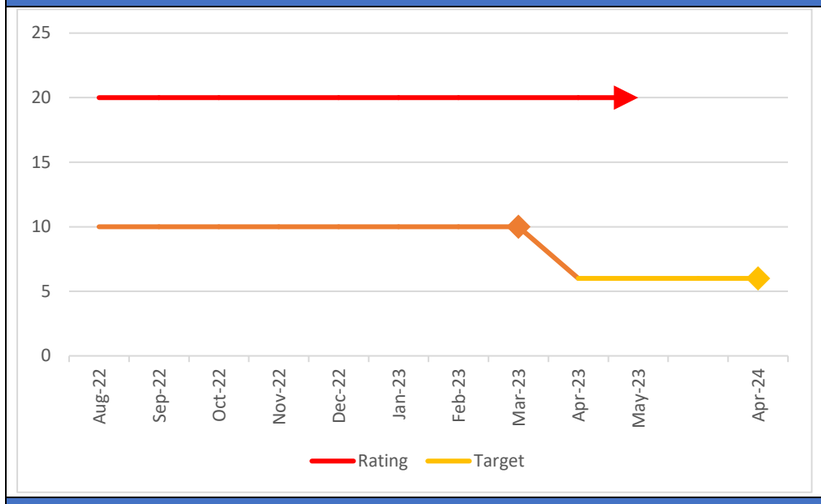
Board Assurance Framework May 2023 – Dashboard

North East London
Integrated Care Board

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score			Target	Risk Appetite – TBC by Board	Order in BAF
				Dec/ Jan	Feb/ Mar	Apr/ May			
To improve outcomes in population health and healthcare	There is a risk that ICS partners do not work together and with local people and communities in collaborative and strengths-based ways and so cannot deliver on our ICS purpose, aims and priorities. This could limit impact on improving the health and wellbeing of local people and reducing health inequalities.	Johanna Moss	ICP Committee	16 NEW RISK TO BAF	12 ↓	12 ↔	8	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	2
To tackle inequalities in outcomes, experience and access	There is a risk that quality and safe care will be adversely affected, reflected in increasing inequalities, poorer outcomes and service failures, when we as a system do not seek to understand and prioritise the experience of local people and to act compassionately and collaboratively with them in response	Diane Jones	Quality, Safety and Improvement Committee	20 NEW RISK TO BAF	20 ↔	20 ↔	8	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	5
	There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents, thereby increasing health inequalities, poorer outcomes and service failures. This could also impact the ability to improve existing services and drive innovation, which in turn could lead to intervention from regulators such as the CQC	Diane Jones	Quality, Safety and Improvement Committee	20 NEW RISK TO BAF	20 ↔	20 ↔	8	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	7
	There is a risk that the failure to work together to produce and implement a coherent, whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support the wellbeing of our diverse workforce and deliver the range of services needed by local people, adversely impacting on their health and wellbeing.	Francesca Okosi	Workforce and Remuneration Committee	12 NEW RISK TO BAF	12 ↔	12 ↔	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	6
To enhance productivity and value for money	There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London. In addition, a failure to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a requirement to go into recovery and potential reductions in services to local people.	Henry Black	Finance, Performance and Investment Committee	20 ↔	20 ↔	20 ↔	10	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	1
	There is a risk that we are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population, due to underinvestment and limited options to secure investment. This could impact on our ability to deliver modern and safe care.	Johanna Moss	Finance, Performance and Investment Committee	N/A	N/A	10 NEW RISK TO BAF	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	8
	There is a risk that if ICS partners do not share mutual accountability for the delivery of current and future operating plans and constitutional standards, this could result in clinical variation and negatively impact on quality and performance improvement. In turn, this could lead to poorer experience and outcomes for service users.	Henry Black	Finance, Performance and Investment Committee	N/A	N/A	15 NEW RISK TO BAF	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	9

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score			Target	Risk Appetite – TBC by Board	Order in BAF
				Dec/ Jan	Feb/ Mar	Apr/ May			
To support broader social and economic development	There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.	Charlotte Pomery	Population Health and Integration Committee	16 ⟷	16 ⟷	16 ⟷	8	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	4
	There is a risk that as the ICB and partners focus on our system and financial challenges, that we become more inward focused and limit our opportunities to work with and influence wider partners across London impacting our ability to improve the health and wellbeing outcomes of local people and communities.	Charlotte Pomery	Population Health and Integration Committee	N/A	N/A	16 NEW RISK TO BAF	8	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	10
	There is a risk that specific populations may be adversely affected if the commitment to being an anti-racist system focussed on equality, diversity and inclusion, is not met. Effects could include poorer quality of care, outcomes and employment opportunities.	Francesca Okosi	Executive Committee	N/A	N/A	15 NEW RISK TO BAF	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	11
	There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation; and social networks and connections.	Paul Gilluley	Population Health and Integration Committee	16 NEW RISK TO BAF	16 ⟷	16 ⟷	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	3

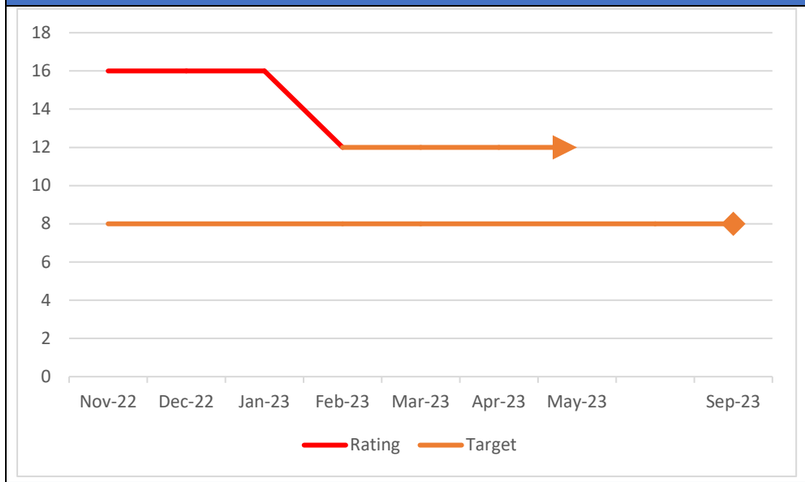
ICS Aim	To enhance productivity and value for money							Risk applies to ICB	Risk applies to ICS	Risk reference	CFPO04 (previously CFPO01)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Henry Black
	✓		✓		✓		✓			Responsible committee	Finance, Performance and Investment Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓				
Risk description	**There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London. In addition, a failure to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a requirement to go into recovery and potential reductions in services to local people.**										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**20 (4x5)**	August 2022 Risk reconsidered in April 2023.	The system has a control total (CT) agreed with NHSE that is required to be delivered. There is considerable risk detailed within the operating plan for NEL at present to the achievement of the CT due to lack of long-term transformation and delivery of cost improvement programmes (CIPs), elective recovery backlog, ongoing operational pressures and workforce shortages. The risk goes beyond a financial risk and impacts on all areas of the system.
	Target rating (LxS)	**Target date**	**Rationale**
	6 (2x3)	April 2024	Mitigations in place should aid the reduction in the risk score and allow the system to deliver its statutory financial duty. However, the prerequisite to this is the reduction in spend across the system.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	20 (4x5)	May 2023	Work is ongoing across the system to address the financial risk NEL that is currently detailed in the operational plan. Efficiency programmes are being led by individual organisations as well as the ICB. This will continue to be monitored across the system and discussed at recovery forums and within CFO meetings. The risk goes beyond a financial risk and requires transformation in order to deliver.

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

Mitigations/ actions to address the risk	Target date
ICS Chief Finance Officers (CFO) meetings with all system partners have been established with outcomes agreed.	31.03.24
System wide formal recovery programme being stood up with key groups to take forward different areas of recovery; including workforce productivity, corporate services and temporary staffing.	31.03.24
System partners have internal efficiency programmes in place to deliver savings for this financial year	31.03.24
Finance team continues to identify ICB savings to be enacted for this financial year to be able to deliver the breakeven position that is statutorily required	31.03.24
Within the ICB - development of recovery plans	31.03.24
Review of investments being undertaken.	31.03.24

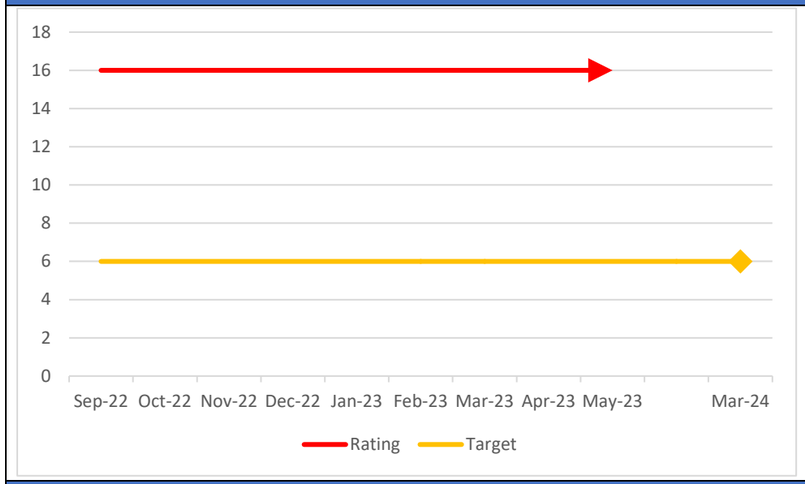
ICS Aim	To improve outcomes in population health and healthcare							Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO01
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Johanna Moss
	✓		✓		✓		✓			Responsible committee	ICP Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓				
Risk description	**There is a risk that ICS partners do not work together and with local people, communities and stakeholders in collaborative and strengths-based ways and so cannot deliver on our ICS purpose, aims and priorities and will have limited impact on improving the health and wellbeing of local people and reducing health inequalities.**										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	Nov 2022	At the point of this risk being identified the extent of engagement required to co-produce the strategy whereby it was jointly owned by all partners was challenging. The reputational and operational impact of not developing a coproduced strategy would be severe as it's one of the key purposes of the ICP to provide the strategic framework for the local health system.
	Target rating (LxS)	**Target date**	**Rationale**
	8	September 2023	Significant work has been planned to ensure there is full engagement with a wide variety of stakeholders and partners reducing the likelihood.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	12 (4x3)	May 2023	This will always remain an important risk for the ICS which we will need to pay attention to. The wider ICS operating model is being developed principally through the leadership and governance work themes, along with critical inputs from the clinical and care professional leadership work theme and the transformation cycle project. These involve co-design by large groups from across the ICS and additional communication with those not directly engaged.

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

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

ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CMO (no. tbc)
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Paul Gilluley
	✓	✓	✓	✓			Responsible committee	Population Health and Integration Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		
Risk description	**There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation; and social networks and connections.**							

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	September 2022	NEL currently has the highest rates of air pollution in the UK and the impact of air pollution on ill health is known and individuals suffer harm because of it. The additional pressure put on the NHS system due to ill health arising from air pollution has a severe operational and reputational risk.
	Target rating (LxS)	**Target date**	**Rationale**
	6	March 2024	An ambitious target to contribute towards the reduction in air pollution locally as a system hence reducing the likelihood and thereby reducing the harm it causes to individuals and the impact on NHS as a whole.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	16 (4x4)	May 2023	The Babies Children and Young People (BCYP) Air Quality Clinical Lead role has been extended. They have worked with the Net Zero Lead and BCYP team to develop a case study for an Air Quality Programme to be discussed with the Chief Transformation and Strategy Officer (CTSO) and Chief Medical Officer (CMO) in May.

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

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

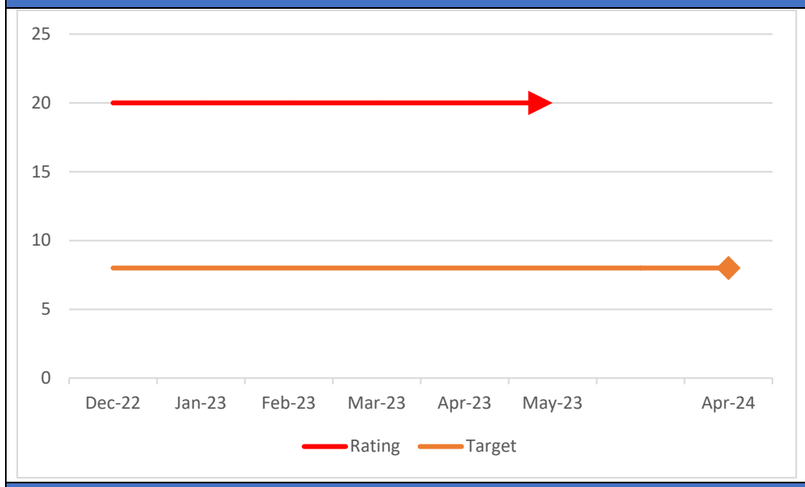
ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO11
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Charlotte Pomery
	✓	✓	✓	✓			Responsible committee	Population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

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	16 (4x4)	November 2022	Given the rapid population growth expected in north east London, there is a need to develop the infrastructure required to support people's health and wellbeing against a challenging economic backdrop.
	Target rating (LxS)	**Target date**	**Rationale**
	8	March 2024	Establishment of the ICS and ICB and all associated structures and governance are still in progress which keeps this as a risk
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	16 (4x4)	May 2023	Local forums have been established as well as a 20-year forecast programme team, however several actions are at their infancy therefore the risk score has not reduced at this stage.

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

Mitigations/ actions to address the risk	Target date
Establishment of Local Infrastructure Forums	Complete
Development of long-term Strategic Infrastructure Approach	March 2024
Dedicated work with local authorities through Place Partnerships and cross-Place Partnership working	Borough-based working is underway.
Progress of development projects such St George's, Havering and the Ilford Exchange in Redbridge.	Project boards are progressing
Implementation of the Fuller stocktake review. Four key workstreams have been developed which are led by an SRO from within the ICS. A proposed governance structure for this work has been developed.	March 2024
A system-wide 20-year forecast programme team has been established.	Complete

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

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	20 (5x4)	December 2022	Considerable system risks that may have an impact on quality and safe care
	Target rating (LxS)	**Target date**	**Rationale**
	8	April 2024	Significant programmes of work are planned or underway that will enable greater oversight across the System
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	20 (5x4)	May 2023	Programme Boards and improved ways of working/ collaboration across the system are starting to be more explicit that this should result in good practice and greater collaboration becoming embedded

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

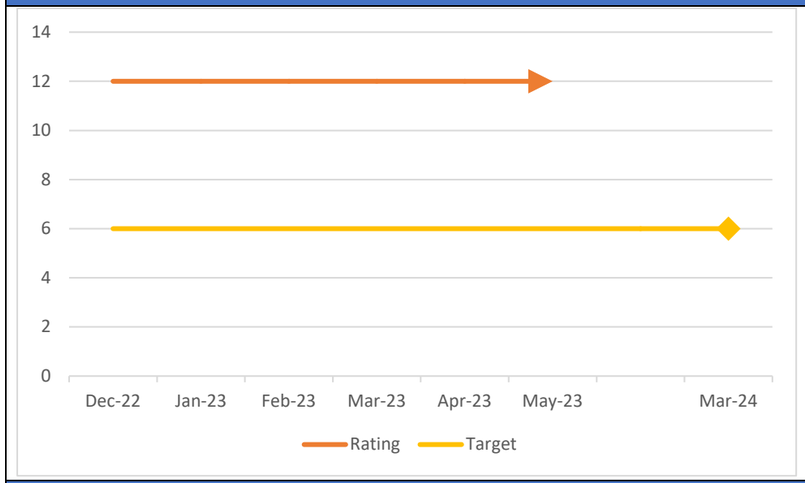
Mitigations/ actions to address the risk	Target date
Escalation discussions taking place across London Chief Nurse network and Chief Medical Officer network - also replicated across NELHCP	
Consideration to be given to areas of clinical activity that could be stood down if needed.	
Review the possibility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

ICS Aim	To tackle inequalities in outcomes, experience and access		Risk applies to ICB	Risk applies to ICS	Risk reference	CPCO02
				✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions	Risk owner	Francesca Okosi
			✓		Responsible committee	Workforce and Remuneration Committee

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

Risk description	There is a risk that the failure to work together to produce and implement a coherent, whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support the wellbeing of our diverse workforce and to deliver the range of services needed by local people with adverse impacts for their health and wellbeing.

Score history and targets

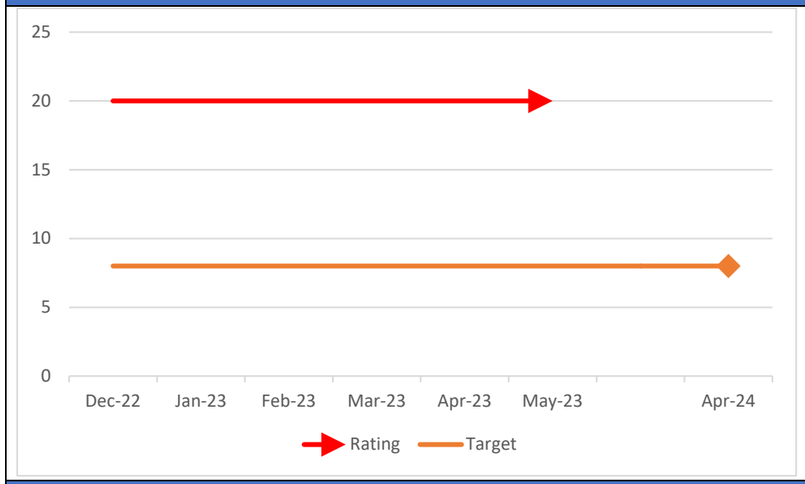


Initial rating (LxS)	Initial date	Rationale
12 (3x4)	December 2022	Given our current service requirements and workforce pressures, that cuts across organisations, if we do not plan and deploy effectively we will not be in a position to deliver the range of services required. And, may impact on the health and well-being of our workforce.
Target rating (LxS)	**Target date**	**Rationale**
6 (2x3)	March 2024	To ensure a consistent and health and well-being offer is maintained for all staff across north east London (NEL). Plans developed and in place to allow flexible deployment and minimum employment of staff across NEL. Development of new roles that can be trained and deployed quickly to NEL utilising apprentice pathways, new roles and retention initiatives. Also to ensure pathways and processes are in place to support and encourage local people into health and care employment.
Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
12 (3x4)	May 2023	Engagement with system partners has started, however there has been delays to the target dates for mitigating actions to address the risk; therefore, the rating has maintained its score.

Controls and assurances
Workforce workshop held 1 November 2022.
High level strategy for discussed at ICB EMT in March 2023
Presentation of the outline strategy to Workforce and Remuneration committee in February 2023
Final strategy for approval and sign off at Executive Leadership Team end of March 2023
Further system workshop held on 24 April 2023.

Mitigations/ actions to address the risk	Target date
Initial engagement with Local Authorities, providers voluntary sector since October 2022	Completed – engagement continues as required
High level outline drafted for overall ICS strategy.	Completed - January 2023
Further engagement with all system partners on further shaping and developing the strategy	Completed - January 2023. Engagement will continue through to mid-April 2023
High level system people and workforce strategy being drafted and presented to the ICB Executive Management Team in May 2023	May 2023
Final high-level system people and workforce strategy to be signed off via ICB Board by July 2023	July 2023
Set up a task and finish group to develop and agree a minimal employment offer and flexible deployment of staff	September 2023
Ensure full utilisation of the levy and infrastructure to support learning in the workplace. Building cohorts of up skilled staff incrementally	January 2024
Through existing health and care recruitment hubs a commitment to offer 900 posts to local residents - incrementally up to 2024 funded by the GLA	January 2023 and ongoing

ICS Aim	To tackle inequalities in outcomes, experience and access							Risk applies to ICB	Risk applies to ICS	Risk reference	CNO (no. tbc)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Diane Jones
	✓		✓		✓		✓			Responsible committee	Quality, Safety and Improvement Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓				
Risk description	**There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents, thereby increasing health inequalities, poorer outcomes and service failures. This could also impact the ability to improve existing services and drive innovation, which in turn could lead to intervention from regulators such as the CQC.**										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**20 (5x4)**	December 2022	Considerable resource and workforce capacity risks that may have an impact on quality and safe care
	Target rating (LxS)	**Target date**	**Rationale**
	8	April 2024	Significant programmes of work are planned or underway that will enable greater oversight across the System
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	20 (5x4)	May 2023	Range of Boards in place and improved ways of working/ collaboration across the system are more embedded – this should result in reduction in risk

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

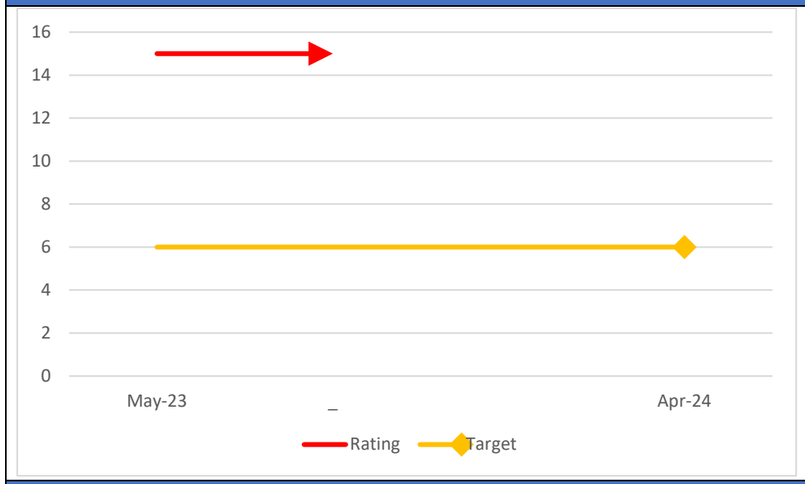
Mitigations/ actions to address the risk	Target date
Escalation discussions taking place across London Chief Nurse network and Chief Medical Officer network - also replicated across NELHCP	
Consideration to be given to areas of clinical activity that could be stood down if needed.	
Review the possibility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

ICS Aim	To enhance productivity and value for money				Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO02
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Johanna Moss
	✓	✓	✓	✓			Responsible committee	Finance, Performance and Investment Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		
Risk description	There is a risk that we are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population, due to underinvestment and limited options to secure investment. This could impact on our ability to deliver modern and safe care.							

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**10 (2x5)**	May 2023	NEL-wide Infrastructure Strategy required by NHS England before December 2023 (TBC). Options and priority areas for investment need to be reviewed to enable better future planning of investment and spend.
	Target rating (LxS)	**Target date**	**Rationale**
	6 (2x3)	March 2024	As work on the strategy starts, this will drive down the severity score as mitigations will be identified.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	Same as initial rating as this is a newly added risk	May 2023	

Controls and assurances	
Internal ICB processes to deliver greater transparency on future spend.	
Implementation of ICB and ICS governance structures which include various committees and sub-committees which are held on monthly or bi-monthly basis with ICS partners.	
Mitigations/ actions to address the risk	**Target date**
Establishment of Local Infrastructure Forums.	March 2024
Development of long-term Strategic Infrastructure Approach.	March 2024
Options and priority areas for investment reviewed to enable better future planning of investment and spend.	March 2024

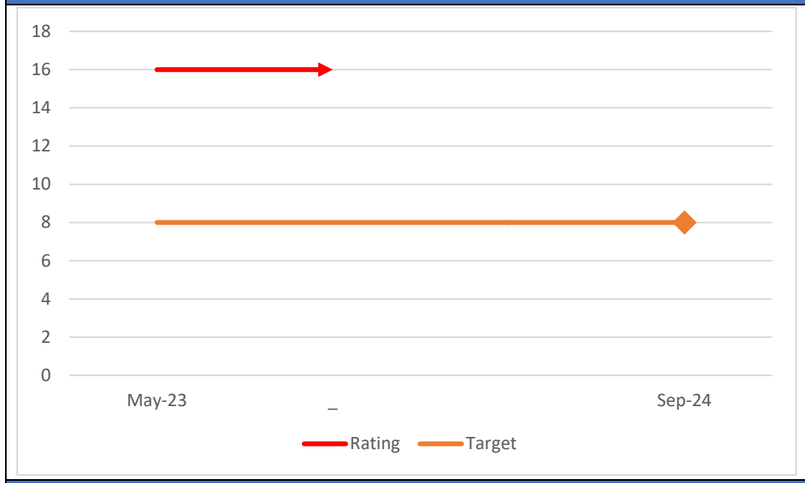
ICS Aim	To enhance productivity and value for money							Risk applies to ICB	Risk applies to ICS	Risk reference	CFPO14/ CFPO15
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Henry Black
	✓		✓		✓		✓			Responsible committee	Finance, Performance and Investment Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓				
Risk description	**There is a risk that if ICS partners do not share mutual accountability for the delivery of current and future operating plans and constitutional standards, this could result in clinical variation and negatively impact on quality and performance improvement. In turn, this could lead to poorer experience and outcomes for service users.**										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**15 (3x5)**	May 2023	There is current experience of co-operation on the 23/24 Operational Plan with shared financial accountability. The exit criteria or the SOF4 status for BHRUT have yet to be clarified. The domain with the highest likelihood of poor outcomes is UEC, where the NEL system has been designated as Tier 1, requiring the highest level of intervention and support.
	Target rating (LxS)	**Target date**	**Rationale**
	6 (3x2)	April 2024	Expectation to deliver UEC recovery plan in the context of Tier 1 designation. Learning from Winter 22/23 to be applied.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	Same as initial rating as this is a newly added risk	May 2023	

Controls and assurances
North East London Cancer Alliance in place and leads on NEL cancer performance and delivery.
Monthly/weekly reviews of all areas are in place along with project governance.
Provider-led Planned Care Delivery Board in place for NEL to address the planned care delivery through local clinically-led recovery programmes, reviews of strategy and approach based around high volume, low complexity care and robust operational oversight and challenge supported by the regional team.
UEC, Community, Mental Health are led through a provider collaborative devolved model of delivery with central ICB co-ordination.
A UEC dashboard has been developed by the NEL business insights (BI) team in cooperation with UEC Programme Board members
The plan to improve UEC performance will receive NHSE assurance as part of Tier 1 process
Research and recommendations commissioned from external consultancy on UEC operational framework

Mitigations/ actions to address the risk	Target date
Provider collaborative-led programmes of work to feed into development of NEL ICB SOF 4 exit criteria driving system-wide solutions, partnership and ICB Exec leadership to exit SOF 4.	To be confirmed
A review of the 22/23 Winter plan has been undertaken to ensure improved safety of patients in 23/24	May 2023
An improvement plan for planned care is in place with clear governance arrangements	Existing
An improvement plan for mental health has been developed	Jan 2023
A plan to improve UEC performance will be produced and delivered as part of the response to Tier 1 designation	Jun 2023

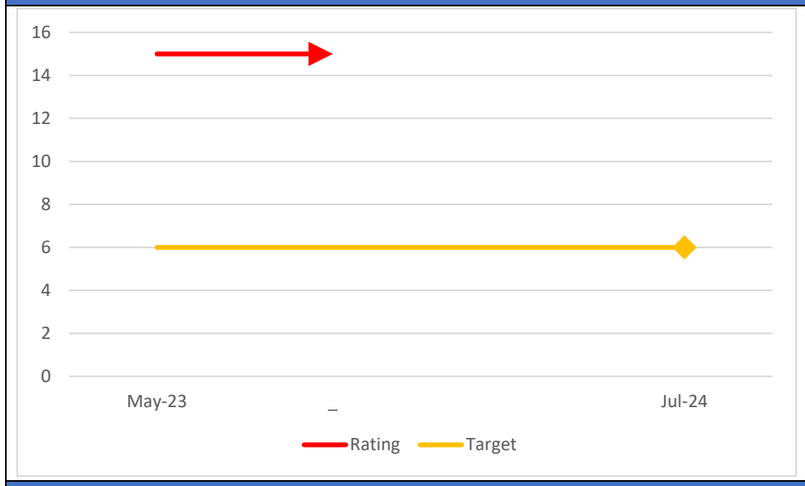
ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO (no.tbc)
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Charlotte Pomery
	✓	✓	✓	✓			Responsible committee	Population Health and Integration Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		
Risk description	**There is a risk that as the ICB and partners focus on our system and financial challenges, that we become more inward focused and limit our opportunities to work with and influence wider partners across London impacting our ability to improve the health and wellbeing outcomes of local people and communities.**							

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	May 2023	The system is facing significant financial challenges and the ICB is going through a restructure, meaning that learning from regional and national can be challenging and time consuming.
	Target rating (LxS)	**Target date**	**Rationale**
	8 (4x2)	September 2024	It is anticipated that over a year will be required and able to fully mitigate this risk - allows significant lead in time following the organisational restructure, as well as understanding the implications of the Hewitt review and wider policy context.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	Same as initial rating as this is a newly added risk	May 2023	

Controls and assurances
Full engagement with partners on regional group and initiatives, including the Greater London Authority.
A focus on learning within and outside of London and attending site visits.
Receiving active delegations from NHS England and hosting services on behalf of London, e.g. Pharmacy, Optometry and Dental Services (PODS).

Mitigations/ actions to address the risk	Target date
Involvement in research and pilot initiatives.	September 24
System leaders participating in national and regional groups.	September 24
The ICB's Managing Director of Primary Care is chair of the Primary Care PODS Group.	Complete.

ICS Aim	To support broader social and economic development							Risk applies to ICB	Risk applies to ICS	Risk reference	CPCO07
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Francesca Okosi
	✓		✓		✓		✓			Responsible committee	Executive Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓				
Risk description	**There is a risk that specific populations may be adversely affected if the commitment to being an anti-racist system focussed on equality, diversity and inclusion, is not met. Effects could include poorer quality of care, outcomes and employment opportunities.**										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**15 (3x5)**	May 2023	This is an initial rating which could have a high severity impact. Work is underway to work through the model to determine an approach.
	Target rating (LxS)	**Target date**	**Rationale**
	6 (2x3)	July 2024	There are several actions to work through to mitigate the risk to the desired tolerance, therefore it is anticipated that over a year will be required to reach this threshold.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	Same as initial rating as this is a newly added risk	May 2023	

Controls and assurances
Good demographic data for our workforce and populations to enable trends to be determined.
The use of demographic profiling to understand the impacts to local residents.
Undertaking equality impact assessments in all areas of work.
Ensuring that all partners have the relevant tool; such as training and access to information.
Working with local government partners at place-level to codesign anti-racist approaches.
Recruitment panels to reflect local populations to support the recruitment processes.

Mitigations/ actions to address the risk	Target date
Strengthening of staff networks to support protected characteristics.	July 2024
Ensuring coproduction reflects local diverse populations.	July 2024
Maintaining our commitment to the Health Inequalities funding which can affect employment opportunities.	July 2024
Co-creating and implementing the Equality, Diversity and Inclusion Strategy.	July 2024
Ensuring that our core communications include community languages.	July 2024

SUPPORTING INFORMATION

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

Committees of the Integrated Care Board:

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

Aims of the Integrated Care System:

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

Risk grading matrix

Risk Category	
	Severe
	High
	Medium
	Low

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

Likelihood					
Rating	**1**	**2**	**3**	**4**	**5**
Description	**Rare**	**Unlikely**	**Possible**	**Likely**	**Certain**
Probability	**<10%**	**10% - 24%**	**25% to 45%**	**50% - 74%**	**>75%**

1	**1**	**2**	**3**	**4**	**5**
2	**2**	**4**	**6**	**8**	**10**
3	**3**	**6**	**9**	**12**	**15**
4	**4**	**8**	**12**	**16**	**20**
5	**5**	**10**	**15**	**20**	**25**

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Audit and Risk committee exception report
Author	Cha Patel, Audit & Risk Committee Chair
Presented by	Cha Patel, Audit & Risk committee Chair
Contact for further information	anna.mcdonald@nhs.net
Executive summary	This report provides a summary of the key items from the meeting held on 24 April 2023.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in March 2023.
Next steps/ onward reporting	The committee meets again on 22 June 2023 and a further report will be presented to the board.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The remit of the committee is to contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management, internal control processes and arrangements to manage conflicts of interest within the ICB.
Impact on finance, performance and quality	N/A
Risks	The Committee will be driven by the organisation's objectives and the associated risks and its duties will be governed by the Terms of Reference. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

1.0 Purpose of the report

1.1 This report provides a summary of the key items from the Audit and Risk Committee meeting held on 24 April 2023.

1.2 The board is asked to note this report.

2.0 Key messages

2.1 Progress on actions required following the Continuing Health Care audit report is slow. Further discussion will take place in the Quality, Safety and Improvement Committee

2.2 Concern continues in regard to procurement and the accuracy of the contracts register. Many waivers are still reported for endorsement, some retrospectively The ICS as a whole will need to drive improvements on the accuracy of the contracts register. The new metric for reporting has seen a big drop in purchase order performance. The national requirement is to achieve 100% Purchase Order usage by April 2024.

2.3 The draft year end accounts 22/23 were robustly reviewed in both the Finance, Performance and Investment Committee and the Audit and Risk Committee and were recommended for forwarding to NHS England (NHSE). The financial outturn was as forecast.

2.4 The draft Annual Report 22/23 was noted, and members agreed to forward comments prior to its submission to NHSE. The final version will be presented to the Audit and Risk Committee prior to Board sign off on 23 June 2023. NHSE will use the report to assess achievement of the statutory duties and aims of the ICB.

2.5 Updates for minor changes were agreed for two governance policies.

2.6 The Committee Effectiveness survey results were discussed and improvements for the future were noted.

2.7 Good progress was reported on risk management incorporating the Board Assurance Framework (BAF). The Committee welcomed the inclusion of digital and estates risks. A draft digital strategy is due to be presented to the Committee at its meeting in June.

2.8 External Audit reported steady progress. Internal Audit issued final reports for Procurement and Contracts Register and Medicines Optimisation. Each receiving partial assurance as expected. Work in progress includes Data Security and Protection Toollkit (DSPT) and the Dental, Optometry and Pharmacy (DOPs) Delegated Duties. The Counter Fraud Functional Standard return 22/23 will be signed off by end May.

2.9 Following a procurement exercise RSM have been re-appointed.

2.10 A verbal update was given on the discussions taking place with NHSE in regard to the draft Operating Plan that was submitted at the end of March. Members noted the challenges and the work that needed to be done ahead of the final submission that was due on 4 May.

3.0 Risks

3.1 Procurement needs a whole ICS response to achieve a quality contracts register. A big improvement is required to achieve the required 100% Purchase Order target.

3.2 The annual report will be used by NHSE to assess ICB effectiveness in meeting statutory duties and aims.

3.3 Achieving a break-even position in 23/24 requires hard choices to be made as well as system agreement and cooperation.

3.4 Both Digital and Estates strategies need to be developed with some parts of the system less well prepared.

3.5 CHC and Medicines Optimisation will need continued focus

Author: Cha Patel
May 2023

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Workforce and Remuneration committee exception report
Author	Anna McDonald, Senior Governance Manager
Presented by	Diane Herbert, Non-executive member
Contact for further information	anna.mcdonald@nhs.net
Executive summary	This report provides an overview of key items from the main meeting held on 4 April 2023 and an additional short meeting held on 2 May 2023.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in March 2023.
Next steps/ onward reporting	The committee meets again on 25 July 2023 and an exception report will be presented to the board going forward.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	Employment and workforce – to work together to create meaningful work opportunities and employment for people in north east London now and in the future.
Impact on local people, health inequalities and sustainability	The Committee will receive assurance on the ICB's Employment Flagship Priority, ensuring that we utilise the ICB's ability to provide meaningful and positive employment opportunities for local residents.
Impact on finance, performance and quality	The Committee and all of its members are bound by the ICB's Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB.
Risks	The Committee will be driven by the organisation's objectives and the associated risks and its duties will be governed by the Terms of Reference. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

1.0 Purpose of the report

1.1 The purpose of this report is to provide an overview of the agenda items discussed at the main committee meeting held on 4 April 2023 and an additional short meeting held on 2 May 2023.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 An overview of the findings of the 2022 national staff survey for NEL ICB was presented to the Committee with a summary of the approach to improve staff

experience. The Committee were advised that 72% of ICB staff had taken part in the survey and that the published results were communicated to all staff via a direct message from Zina Etheridge, Chief Executive Officer followed by a staff briefing.

2.1.1 Committee members were advised that there are a number of areas requiring improvement and received assurance that the Chief Executive and the executive management team committed to the following three key areas of focus in the first instance:

- Ensuring the process for the organisational restructure is fair, clear and transparent and that staff are made aware of the next steps, particularly in regard to ensuring the process for recruiting to any vacancies is robust and that everyone has access to opportunities.
- Addressing inequitable experiences to create a truly inclusive organisation that in turn, enables us to serve the diverse communities of north east London.
- Decrease the proportion of people experiencing bullying and harassment.

2.1.2 Picker has been commissioned to undertake a further analysis that will help to identify further areas of focus, and the results of the analysis are expected to be received by the end of May.

2.1.3 The executive management team and departmental leaders will be accountable for developing a robust action plan with the involvement of staff across the organisation, including our staff networks, to design changes that include areas such as appraisals and leadership development.

2.1.4 A whole cultural re-development programme across the ICB is needed so that we have one set of standards and values that we are all working to.

2.1.5 As part of the discussion, the Committee acknowledged that although some of the results are challenging, there are some positives and reasons for optimism and the Chair suggested the need to examine positive scores to know what they are really telling us

2.2 An update on the ICB's re-organisation was presented and members received assurance on how the process is being kept as transparent as possible and that there is a robust process to ensure Equality Impact Assessments are being undertaken and interview panels are as fair and transparent as possible.

2.3 The Committee received an update on progress in regard to the Workforce Strategy including a summary of the key themes identified from the active engagement with ICS colleagues including local authorities, primary care and the voluntary sector.

2.4 An additional short Committee meeting was held on 2 May 2023 where the Committee approved the submission of a voluntary redundancy scheme to NHS England in line with Section 16 of Agenda for Change for use by North East London ICB.

3.0 Risks and mitigations

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

Author: Anna McDonald, Senior Governance Manager
May 2023

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Quality Safety and Improvement (QSI) committee exception report
Author	Dotun Adepoju, Senior Governance Manager
Presented by	Imelda Redmond, Non-Executive Member
Contact for further information	dotun.adepoju@nhs.net
Executive summary	• The fourth meeting of the Quality Safety and Improvement (QSI) Committee was held on 26 April 2023 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. • Following from discussion at its previous meeting of 8 February on industrial action by and ambulance staff, nurses and junior doctors, the committee had asked for feedback at its next meeting with a focus on any known / measurable impact to residents. The meeting heard that actual harm directly related to industrial action was not known however this is a live discussion through the System Incident Management meeting. The next Clinical Advisory Group meeting will have a focus on this and the Committee asked for feedback at the next meeting. • New statutory guidance was published on 16 December 2022 which requires organisations to work together to prevent and reduce serious violence within our local population. • The strategic risks within the Chief Nursing Officer (CNO) portfolio areas were also discussed and the Committee welcomed that all red rated risks continue to be discussed at each Committee meeting. • The Quality Highlight report outlined assurance, improvement and exception matters pertaining to a range of CNO function areas, presented as NEL issues and across Place. This included an update on the work being supported by the safeguarding teams with regards to Contingency hotels across NEL to enable safeguarding duties to eb discharged; progress made by BHRUT with their CQC action plan; system issues being identified through the Individual Funding Request process and safeguarding programmes of work across Place • Finally, the Committee received the draft ICB all age Safeguarding Strategy that outlined how the ICB would discharge its Safeguarding duties and sought some further assurances around how this works with the statutory Boards and Partnerships across Place

Action required	The board is asked to: • Note the areas of quality improvement and quality assurance discussed by the QSI committee
Previous reporting	The topics covered in this report have previously been considered and scrutinised by the QSI committee.
Next steps/ onward reporting	Actions are in place to address the BHRUT CQC findings and be mitigated through the BHRUT CQC Improvement Plan Continue the safeguarding support work with regards to the Contingency Hotels across NEL Continued support for PELC through the Enhanced Surveillance approach to drive organisational improvements and change identified by the CQC
Conflicts of interest	There are no known conflicts of interest
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	Each topic is an area of service delivery which aims to improve the quality of care for local people through recognising opportunities for quality improvement.
Impact on finance, performance and quality	All the topics highlight areas for further quality improvements, particularly where joint working at place is beneficial for local delivery.
Risks	Of the topics discussed by QSI the greatest risks noted are those related to tackling inequalities in outcomes, experience and access. The risk related to the CHC Digital Systems procurement process has been paused. One of the mitigation actions is to develop a funding envelope for the new system including mobilisation costs.

Quality Safety and Improvement committee exception report

1.0 Purpose of the report

1.1 This report provides the Board with an overview of the items discussed at the QSI committee held on 26 April 2023 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. There were rich discussions reflecting the strategic importance of the papers presented to the work of all partners.

1.2 The Board is asked to note this report.

2.0 Key messages

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

2.2 The Committee discussed the impact on quality and patients' safety of the industrial action taken place in recent weeks. Actual harm to patients throughout the industrial action is not known at this stage . System partners agree that actual harm is difficult to track back to industrial action at this stage but it is likely to work through the system. Skeletal workforce during previous episodes of industrial action and the junior doctor industrial action after the Easter break was likely to have an impact on patients. Elective procedures and outpatient appointments were cancelled due to industrial action. No serious incidents have been reported by providers as a result of industrial action. The Committee were informed that the next Clinical Advisory Group were to have a deep dive on the impact on patient safety and quality and have requested an update at the next Committee

2.3 The Committee acknowledged the establishment of the new statutory guidance which was published on 16 December 2022 requiring organisations to work together to prevent and reduce serious violence within our local population. It noted that the ICB is a responsible authority along with police, local authority and other partners. It noted how the ICB strategy would need to complement similarly geared plans and strategies at place taking onboard local plans and arrangements.

2.4 The committee received the Quality Highlight report, acknowledging the improvement of reporting of the breadth of quality issues, which covered:

- System issues such as the work undertaken by the ICB safeguarding teams with regards to Contingency Hotels to ensure safeguarding pathways are clear and how the work is being taken forward through place-based refugee and asylum seeker task and finish groups; progress being made by BHRUT with regards to their CQC Improvement Plan. A verbal update was also given with regards to the ongoing enhanced surveillance of PELC following their CQC reports which placed a number of enforcement notices upon them and how the CQC will be revisiting in June to assess improvement
- Quality at Place reported as system issues across Place covering Acute, Community, Mental Health, Primary Care and Social Care. The Committee welcomed the commitment to include more information regarding General Practice quality matters at future meetings
- Individual Funding Requests (IFR) and how they can support transformation discussions going forward based on themes and trends arising from IFRs
- Adult Safeguarding and Children Safeguarding
- Maternity – the Committee sought clarity on the strategic risks regarding maternity and which programmes of work are in place to mitigate and drive improvements in maternity services across NEL and requested a further update at a future meeting
- Infection prevention and control (IPC)

3.0 **Risks and Mitigations**

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

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

Dotun Adepoju, 16 May 2023 2023

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Finance, Performance and Investment Committee exception report
Author	Matthew Knell, Senior Governance Manager
Presented by	Henry Black, Chief Finance and Performance Officer Kash Pandya, Associate non-executive member/ Chair of the Finance, Performance and Investment Committee
Contact for further information	matthew.knell@nhs.net
Executive position summary	The Finance, Performance and Investment Committee (FPIC) has met twice since the March 2023 ICB Board – it's meeting of Monday 27 March 2023 discussed the following business: • Month 9, 2022-23 Performance and Month 11, 2022-23 Finance Reports; • The Finance and Performance risk register • The March 2023 submission of the 2023/24 operating plan • NEL status against the NHS System Oversight Framework (SOF) 2022/23 • Continuing Health Care (CHC) Any Qualified Provider (AQP) / non-AQP cost uplifts for 2023/24 • A business case for Tower Hamlets, Newham and Waltham Forest Ear, Nose & Throat Community Service • A Primary Care Rebate Scheme for Freestyle Libre The FPIC also met on Monday 24 April 2023 to consider and endorse the draft 2022/23 Annual Accounts ahead of Audit Committee consideration and also received an update on revisions to the 2023/24 Operating Plan.
Action required	The Board is asked to note the report.
Previous reporting	None – this is an exception report from the March and April 2023 Committee meetings.
Next steps/ onward reporting	The Committee meets again on Tuesday 30 May 2023 and a regular exception report will be presented to the Board along with any approved minutes.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	Which of the ICS aims does this report align with? • To enhance productivity and value for money • To support broader social and economic development

Impact on local people, health inequalities and sustainability	One of the Committee's responsibilities is to review and approve allocation of contingency funding which is to include transformation, productivity and to aid the reduction of health inequalities for the residents of North East London.
Impact on finance, performance and quality	The Committee is established to provide assurance and oversight to the Board on the robustness of the short- and long-term financial strategy and management for the ICB. It will provide assurance to the ICB on operational performance as it relates to the Operational Planning guidance for acute and non-acute metrics, both constitutional and non-constitutional standards as appropriate.
Risks	The duties of the Committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

1.0 Introduction / Context / Background / Purpose of the report

1.1 Meetings of the Finance, Performance and Investment Committee (FPIC) have taken place on Monday 27 March 2023 and Monday 24 April 2023 and this exception report outlines the key messages, recommendations, decisions and actions taken by FPIC members in accordance with its terms of reference.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 In March 2023, the Committee received an update on the current performance and financial position for the ICS and the ICB, which included information on Month 9 (December 2022) performance (with month10 urgent & emergency care data) and Month 11 (February 2023) finances. The Committee discussed the challenging winter, progress against reducing waiting lists and the impacts of industrial action on the area, along with the agreement to move to a year end system deficit position with support from NHS England. The Committee examined the underlying drivers of this financial performance and approved proposals to enter in to section 75 and section 256 agreements with partner local authorities for the virtual wards and the babies and young people programmes.

2.2 The Committee received and discussed the draft 2023/24 Operating Plan that was to be submitted to NHSE at the end of March 2023, recognising NEL's compliance with most, but not all national objectives and key targets. It was recognised that work is underway to explore and address those identified as more challenging to achieve. Discussions centred on that the plan included a workforce plan with minimal growth, but with a shift away from the use of agency and bank staff and towards recruitment of permanent staff. The plan set out a budget with spend slightly higher on acute services and it was confirmed that the mental health investment standard (MHIS) would be met. FPIC members recognised and expressed concern that the plan contained significant risk, and set out a deficit position, with NHSE expected to seek engagement with the ICB regarding its contents.

2.3 The Committee recognised that the ICS remained in System Oversight Framework (SOF) 3, with Barking, Havering and Redbridge NHS Trust (BHRUT) in SOF 4 measures. In response, a Financial Recovery Group had been set up and exit criteria for BHRUT to move out of SOF 4 had been agreed and a work plan was in place. Exit criteria for the ICS to move to SOF 2 were under development.

2.4 The Committee approved that the ICB should join the Pan-London AQP Nursing home standard weekly rate, while a lower uplift would be offered for Non AQP Nursing Homes and Domiciliary Care providers, in line with other London ICBs. This follows on from recommendations from, and work undertaken by the London Purchased Healthcare (LPH) Team to agree higher than normal annual uplifts to help address cost of living and inflationary pressures. It is anticipated that the lower figure for non AQP arrangements will encourage providers to become part of the AQP framework.

2.5 The Committee approved a proposal for a Tower Hamlets, Newham and Waltham Forest Ear, Nose and Throat (ENT) Community service. This service would take the currently live pilot service on to a recurrently funded position, secured through financial reduction (underperformance) in the Barts Contract for ENT.

2.6 The Committee approved a proposal to enter in to a Primary Care Rebate Scheme (PCRS) for use of Freestyle Libre, offered by Abbotts and evaluated by the ICB Pharmacy and Medicine's Optimisation Team for 12 months with the option to extend for a further 12 months.

2.7 The FPIC met for a shorter than usual session in April 2023 to examine and endorse the draft 2022/23 Annual Accounts ahead of Audit Committee consideration. The meeting also received a revised 2023/24 operating plan following feedback and discussions with NHSE. Members recognised that this new version of the plan met the statutory requirement to secure a breakeven position, although this would be supported through excess inflation and/or supersurge funding from NHSE and be reliant on the local system addressing the remaining gap in the financial position. Discussions had commenced with local partners to identify and document achievable savings through more substantial routes than utilised in the past, along with increasing grip on non-recurrent spend, innovation funding and all contracts to produce the required position through the year. Against this background, vital work needed to continue to ensure that out of hospital services remain well supported and that the movement of activity from the acute setting to the community was on track - embracing partnership working and sharing of best practices to look at any cost differences across NEL Trusts. The FPIC emphasised that partners would need to work together to develop a series of 'system rules' and incentives to steer providers, with the FPIC holding a key role in leading and influencing this discussion to hold a consistent position across the area and promote co-operation to save, share costs or activity across partners. Any discussion or proposed changes needed to involve the patient voice and directly address patient need and the needs of local communities from the start and be steered by a clear clinical strategy.

3.0 Risks and mitigations

3.1 The Committee received the latest Finance and Performance Directorate Risk Register in March 2023, containing red risks rated at 12 and above and recognised that this remained work in progress and that risks needed to be developed and

documented around the 2023/24 operating plan and any financial impacts of the known workforce challenges.

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

Author: Matthew Knell, Senior Governance Manager
Date: 12/05/2023

North East London
Integrated Care Board

NHS North East London ICB board

31 May 2023

Title of report	Population Health and Integration committee exception report
Author	Katie McDonald, Governance Manager
Presented by	Marie Gabriel, ICS Chair/ Chair of the Population Health and Integration Committee
Contact for further information	katie.mcdonald3@nhs.net
Executive summary	This report provides a summary of the key items from the meeting held on 26 April 2023.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in March 2023.
Next steps/ onward reporting	The committee meets again on 21 June 2023 and a further report will be presented to the board.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access
Impact on local people, health inequalities and sustainability	The remit of the committee is to identify opportunities to support and improve effective population health management and integration of health and care services at place and within collaboratives for the residents of north east London.
Impact on finance, performance and quality	N/A
Risks	The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

1.0 Purpose of the report

1.1 The Population Health and Integration Committee was held on 26 April 2023 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. There were rich discussions reflecting the strategic importance of the papers presented to the work of all partners.

1.2 The board is asked to note this report.

2.0 Key messages

2.1 The Population Health and Integration Committee (the Committee) received a deep dive presentation from the Redbridge borough partnership which focused on its work in relation to local prevalence of multiple Long-Term Conditions (LTCs), including:

- Diabetes
- Hypertension

- Atrial fibrillation
- Coronary heart disease and heart failure
- Chronic obstructive pulmonary disease
- Asthma
- Chronic kidney disease

2.2 Members discussed the stigma associated with having multiple LTCs and the deeper psychology involved, which highlighted the need for patients to receive continuity of care as well as sufficient time to talk to their clinician and other trusted people in order to receive assurance as well as reassurance. The importance of supporting 15-minute neighbourhoods will be key to strengthening this work due to the unique nature of communities and the benefits of working at a hyper-local level.

2.3 It was noted that there may be opportunities to affect the commissioning of primary care services to enhance continuity of care and reduce clinical variation as the responsibility of commissioning these services has now been transferred to ICBs.

2.4 The committee discussed the importance of recognising that there are four types of knowledge to be considered when identifying performance gaps:

- Propositional
- Factual
- Presentational
- Experiential

It is common that propositional and factual knowledge are considered whereas experiential knowledge is the least likely to receive focus, however all should be considered when reaching conclusions about improvement and priorities as the discussion on stigma demonstrated.

2.5 The committee received reports from each of its sub-committees which had a theme of ‘what do we mean by integration?’. The reports highlighted the range of integration underway, including developing a Committees in Common model, the use of aligned and pooled budgets, and integrated leadership and management structures.

2.6 The reports also underlined the need for a range of enablers to be in place to support increasing focus on integration including the need for trust to be embedded throughout organisations, alignment of processes and the ability to take opportunities when they arise. The Committee discussed its role in bringing together Places and Collaboratives to enable further integration and sharing of best practice.

3.0 Risks and mitigations

3.1 The duties of the committee will be driven by the ICS and organisation’s objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks. There are no additional risks arising as a result of this report.

Author: Katie McDonald, Governance Manager
ate: 15.05.2023

North East London
Integrated Care Board

Integrated Care Board Forward Plan

	25-Jan-23	29-Mar-23	31-May-23	23-Jun-23	26-Jul-23	27-Sep-23	29-Nov-23	31-Jan-23	27-Mar-23
Resident story									
Update on previous resident stories									
Chair and chief executive reports									
Chair's report									
Chief executive officer's report									
Governance									
Executive committee exception report									
QSI committee exception report									
FPI committee exception report									
PHI committee exception report									
Audit and risk committee exception report									
Workforce and remuneration committee exception report									
Approval of governance handbook amendments									
Approval of the annual report and accounts									
Denistry, Optometry and Pharmacy (DOP) Delegation									
Approval of Corporate Objectives									
Finance and Performance									
Overview report									
2023/24 budget									
Assurance									
Board Assurance Framework									
Quality									
Commissioner/ICB Statements for Provider Quality Accounts									
Safeguarding annual reports (Adults, Children and LAC) (TBC)							TBD		
LeDeR Annual Report							TBD		
CDOP Annual Reports							TBD		
Deep dives		Urgent and emergency care	Mental Health		Primary care	Urgent and emergency care	Babies, children and young people		
Quality report									
Strategy									
Integrated Care Strategy									
Updated working with people and communities strategy									
Joint forward plan (5 year plan)				TBD					
Clinical Care Leadership Strategy									
Finance Strategy									
Operating plan									
Estates strategy									
Making north east London a London Living Wage place									

Items for Board development sessions:

- How we are working together and how effective we are in preparation for further review in September of ICB/Governance effectiveness.
- Methodology for identifying main and marginal system priorities