

NHS North East London Integrated Care Board

23 June 2023, 1.30pm – 2.30pm; Microsoft Teams

Agenda

| | Item | Time | Lead | Attached/ verbal | Action required |
|---|--|-------------|-------------|-----------------------------|----------------------------|
| 1.0 | Welcome, introductions and apologies | 1.30 | Chair | Verbal | Note |
| 1.1. | Declaration of conflicts of interest | | | Attached | Note |
| 2.0 | Annual report and accounts <ul style="list-style-type: none">• April 22 – June 22 CCG annual report and accounts (Q1)• July 22 – March 23 ICB annual report and accounts (Q2-Q4) | 1.35 | CPo/ HB | Attached | Approve |
| 3.0 | Questions from the public | 2.10 | Chair | Verbal | Discuss |
| 4.0 | Any other business and close | 2.25 | Chair | Verbal | Discuss |
| Date of next meeting: 26 July 2023 | | | | | |

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 |

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|--------------------------|---------------------------------------|--|-------------------------------------|--|---|------------|----------|--|
| 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 | | |

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|---------------|---|--|-------------------------------------|--|--|------------|----------|--|
| 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 | | |

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|---------------|--------------------------------|--|-------------------------------------|--|--|------------|----------|--|
| 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 | | |

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|----------------|--|--|-------------------|--------------------------------------|---|------------|----------|--|
| 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 ICB board

23 June 2023

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| Title of report | Annual report and annual accounts - CCG Q1 and NHS North East London - Q2 to Q4 2022/23 |
| Author | Marie Price, Director of Communication and Involvement Marie.price9@nhs.net |
| Presented by | Charlotte Pomery, Chief Participation and Place Officer Henry Black, Chief Finance & Performance Officer |
| Contact for further information | As above |
| Executive summary | <p>Integrated Care Boards (ICBs) are required to publish as a single document, an annual report, accountable officer statement and annual accounts. National annual reporting guidance refers to compliance with the Manual of Accounts issued by the Department of Health and this in turn complies with the Government's Financial Reporting Manual. There is a common format for ease of national collation.</p> <p>NHS North East London ICB is required to submit an annual report and signed final audited year end accounts for the period 1 July 2022 to 31 March 2023 to NHS England by 30 June 2023.</p> <p>The submission will also include signed audited accounts for the legacy NEL CCG for the period 1 April 2022 to 30 June 2022 and final Head of Internal Audit Opinion.</p> <p>The initial draft annual report and accounts were discussed at the Audit and Risk Committee meeting on 24 April. Colleagues have considered and addressed the comments received from auditors, NHS England, committee members, executives and ICB Chair.</p> <p>Despite a challenging context with the impact of transitioning from a CCG to an ICB, colleagues have met the requirements to date and are on track, subject to agreement at this meeting, to submit the final version as required by 30 June 2023 having been signed off by the ICB's Chief Executive Officer.</p> <p>On 22 June, the Audit and Risk Committee will review the final draft and will be asked to recommend that the annual report and accounts are approved by the ICB board and also recommend the ICB board delegates authority to the Chief Executive Officer, Chief Finance and Performance Officer and the Audit and Risk Committee chair to resolve any issues should they arise before the final submission deadline of 30 June 2023. The outcome of the Audit and Risk Committee's</p> |

| | |
|---|--|
| | <p>decision regarding whether to recommend approval will be provided by way of a verbal update at the meeting.</p> <p>The ICB is required to publish CCG and ICB annual reports and accounts alongside the External Auditor's annual report on its public facing website. A summary, more user-friendly version of the annual report will also be produced which will be shared more widely with local people and stakeholders.</p> |
| Action / recommendation | <p>The ICB board is asked to:</p> <ul style="list-style-type: none"> • Advise of any final corrections needed to the annual reports and annual accounts • Approve the annual reports and annual accounts (legacy CCG and ICB) • Agree to delegate authority to the Chief Executive Officer, Chief Finance and Performance Officer and the Audit and Risk Committee chair to resolve any issues should they arise before the final submission deadline on 30 June 2023 |
| Previous reporting | <p>Finance, Performance and Investment Committee Audit and Risk Committee</p> |
| Next steps/ onward reporting | <p>Submission to NHS England</p> |
| Conflicts of interest | <p>There are no conflicts of interest identified in relation to this report.</p> |
| Strategic fit | <p>The annual report content reflects on the strategic priorities.</p> |
| Impact on local people, health inequalities and sustainability | <p>The annual report includes details on the impact of the ICB's activities on local people, health inequalities and sustainability and when published will provide information and assurance on progress.</p> |
| Impact on finance, performance and quality | <p>As above, the annual reports and accounts provide transparent information on the ICB's progress in these areas.</p> |
| Risks | <p>The key risk to the ICB is that the annual reports and annual accounts are not submitted to meet national timelines, however all deadlines so far have been met and subject to agreement at this meeting, the final deadline will also be met.</p> |

June 2023

NHS North East London Clinical Commissioning Group

Report and Accounts 1 April – 30 June 2022

Abbreviations used in this report

| | |
|---------------|---|
| BHR | Barking and Dagenham, Havering and Redbridge |
| BHRUT | Barking Havering and Redbridge University Hospitals NHS Trust |
| ED | emergency department |
| ENT | ear, nose and throat |
| CCG | Clinical Commissioning Group |
| CQC | Care Quality Commission |
| CETV | cash equivalent transfer value |
| NELHCP | North East London Health and Care Partnership |
| GB | Governing Body |
| IAPT | Improving Access to Psychological Therapies |
| ICO | Information Commissioners Office |
| ICB | Integrated Care Board |
| ICP | Integrated Care Partnership |
| ICPB | Integrated Care Partnership Board |
| ICS | Integrated Care System |
| IPC | Infection Prevention Committee |
| IG | information governance |
| GBAF | governing body assurance framework |
| JSNA | joint strategic needs assessment |
| NEL | north east London |
| NELFT | NELFT NHS Foundation Trust |
| NHSE | NHS England |
| PCN | Primary Care Network |
| RTT | referral to treatment time |

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PERFORMANCE REPORT



Zina Etheridge

Accountable Officer

5 October 2022

Performance Overview

Introduction

Clinical Commissioning Groups (CCGs) were abolished from 1 July 2022. This report covers the three month period between 1 April and 30 June 2022, which continued to be a challenging time for our local health and care system. In addition to continued recovery of services post-pandemic, we also oversaw significant organisation and system change brought about by the Health and Social Care Act 2022, which came into law in April 2022. Our focus was to ensure a safe closedown of the North East London Clinical Commissioning Group (CCG) and preparedness for establishment of the new NHS North East London Integrated Care Board (ICB) and wider integrated care system – the North East London Health and Care Partnership.

The first part of the report sets out how the CCG, with our system partners continued to focus on restoring services, increasingly face to face and to treat people whose planned care had been delayed. This included cancer diagnosis and care, where the North East London (NEL) Cancer Alliance continues to perform well. We improved access to diagnostics through successful funding bids to region and installed new scanning equipment, with further diagnostic facilities planned over the coming years. Much of this good work was based on increased collaboration across partners, begun in earnest during the pandemic.

With our partners, we developed and agreed two important strategies setting out our ambition as an integrated care system for resident participation and sustainable development, underlining our commitment to putting people and our environment at the heart of all we do. We say more about this in the next section.

We met our financial requirements for this first quarter, but given the wider economic picture we will need to work across our system to mitigate the risks impacting on NHS, local authority and partner costs and budgets. Within this we recognise the considerable cost of living impact on our population, many of whom are already the most economically deprived in the country. Partners are working collaboratively so that together we support people through the difficult winter period ahead.

Teams across all CCG departments worked hard to ensure we closed down the organisation safely, with the programme, governance, finance, HR and legal colleagues leading this work, while at the same time ensuring the new ICB and wider ICS systems were established for launch on 1 July. The transition happened in a smooth and organised way, with independent assurance provided by our auditors and external legal advisors.

We reflected on the good things the NEL and former CCGs had achieved through sessions with all staff and the governing body, thanking them, our partners and GP members for all their input as well as considering what we wanted to take with us into the new system. We are building on this good work as

we enter the next phase, where we now have increased ability and impetus through the legislation to embed truly integrated and partnership working at each of our seven places and through our collaboratives of NHS and voluntary sector partners.

This is the final 'annual' report of the CCG, shorter due to timeframe for approving the legislation which abolished CCGs, but in the following sections we reflect on what we achieved in this short period and we are well placed to now focus on delivering our partnership aims, objectives and ambition for north east London. NEL CCG helped to establish this foundation.

Performance Analysis

Our focus remained on restoring services, addressing waiting lists, and working differently to accelerate delivery and working through a set of nationally determined priorities:

- Supporting the health and wellbeing of staff and acting on recruitment and retention.
- Delivering the NHS Covid vaccination programme and continuing to meet the needs of patients with Covid.
- Building on what we learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.

Protecting and supporting our staff to stay safe was a priority through the pandemic and enabled delivery of patient care through flexible working, infection prevention and control policy, testing policy, as well as drawing on the range of preventative health and wellbeing support available.

During the pandemic, staff adopted innovative ways of working to make best use of their skills and experience to benefit patients through flexibility of staff movement across systems. This included remote working plans, technology enhanced learning and the option of a [Digital Staff Passport](#) which enable safe and rapid staff movements between NHS organisations to help staff work flexibly and cut admin costs.

Restoring Elective Services

The pandemic had a significant impact on NHS activity, and while the majority of care and activity was maintained through the winter, there continue to be new and increased demands on mental health services. It also had a significant impact on the delivery of elective care, such as planned or routine

surgery or courses of treatment, and, as a result, on the lives of many patients who are waiting for treatment.

Our acute trusts have worked towards restoring services back to pre-pandemic levels. By the end of June this was close to 100%, with plans to increase this further in 2022/23, including the need to fully utilise the support of independent sector providers. The process of restoring routine planned services has been led by our brilliant frontline clinicians, and they have shown a real energy and flair for innovation. For example, a series of 'blitz' weeks were carried out to target certain specialties with long waiting list e.g. Bones Week, Project Gastronomaut, Project Scalpal, ear, nose and throat (ENT) Kidz at BHRUT.

Increased collaboration and partnership working across our acute trusts has also led to greater opportunities to share this learning across our system. This allowed for patients to be treated more quickly by sharing capacity across the hospitals for six high volume, low complexity specialities i.e. trauma and orthopaedics, urology, gynaecology, ophthalmology, general surgery and ENT. The focus has been on treating patients waiting over one and two years.

For the latest reported month of June 22, NEL ICS had 9,035 patients waiting over a year and 186 waiting over two years, a significant reduction in the number of patients waiting over two years. Performance against the referral to treatment (RTT) standard as reported in June was 60.62% against the 92% standard for treatment of patients within 18 weeks.

Reducing Risk of Infection

Patient safety continued to be a priority and measures to reduce the spread of infection continued to be implemented. This included segregating elective care flow through the hospital, prioritising the clinically most urgent patients, e.g. for cancer and urgent surgical treatments, maintaining effective communication with patients including proactively reaching out to those who are clinically vulnerable and addressing the longest waiting patients.

Transforming Outpatient Services

During the pandemic we saw a significant system-wide effort to embed outpatient transformation, taking all possible steps to redeploy capacity that may previously have been used for less urgent or complex outpatient activity to where it was most needed, alongside increased use of services like advice and guidance, or advice and refer, which ensures that GPs get access to specialist advice enabling better care for patients outside of the hospital. Some of these arrangements are still in place to ensure we focus on care where it is needed most. North east London has the highest rate of advice and guidance, at approximately 21% compared to the national requirement of 12%.

Where outpatient attendances are clinically necessary, our trusts delivered about 21% remotely by telephone or video consultation, enabling vulnerable people to shield at home and avoid the risk of infection whilst ensuring face-to-face care for those patients with greatest need.

The first quarter also saw a focus on increasing diagnostic capacity with plans for the development of community diagnostic hubs starting to take shape. In order to tackle the pandemic backlog, acute provider trusts have focused on returning to pre-pandemic levels of activity, and in some cases well above 100%, for certain modalities and a focus on those with the longest waiting times, magnetic resonance imaging (MRI) and CT scans.

Prioritising Cancer Services

Restoration of full operation of all cancer services continued to be a focus and teams worked hard to prioritise cancer services during the pandemic, and the overwhelming majority of cancer treatment has continued. However, there were far fewer patients contacting their GP with symptoms, which suggests the pandemic had an impact on people coming forward to report issues that may have been early signs of cancer. This had an impact on the ability to ensure early diagnosis and treatment of patients. The NEL Cancer Alliance has worked with GPs and the local population to increase the number of people coming forward and being referred with suspected cancer, with a particular focus on under-represented groups. More information on the work of the NEL Cancer Alliance can be found on the NELHCP website.

The Cancer Alliance has been working with partners across NEL to ensure that there is sufficient diagnostic and treatment capacity in place to meet the needs of cancer patients and return the number of people waiting for longer than 62 days for treatment to the level we saw in February 2020. Despite the challenges through the pandemic, performance against the cancer constitutional standards has been strong in NEL and the latest reported month of June 2022 saw compliance against the two-week wait standard with performance of 93.51% against the 93% standard, 66.79% against the 85% 62 day standard and delivery of 79.49% against the 75% Faster Diagnosis standard.

Improving Access to Diagnostics

The Mile End Early Diagnostic centre has provided additional diagnostic capacity to ensure rapid investigation and diagnosis. There was also a significant increase in the take up of innovations like colon capsule endoscopy and Cytosponge to support effective clinical prioritisation for diagnostics, and rapid diagnostic centres are in place in both inner and outer north east London. The 'Targeted Lung Health Check' programme has also continued.

The Diagnostics team has achieved good progress with supporting the development and deployment of the national Community Diagnostics Centres (CDC) programme. This has involved achieving £6m of additional revenue funding to deliver thousands of additional diagnostic procedures, as part of the 'early adopter' programme. We have also pressed ahead with the installation of a new MRI scanner in the Mile End Hospital (MEH) CDC and a CT scanner at Barking Community Hospital (BCH) CDC. The business cases for our potential full CDCs in MEH and BCH and overall strategy for the CDCs have also been developed and provisionally agreed during this period.

NEL ICS performance against the 1% diagnostics standard (less than 1% of patients should wait 6 weeks or more for a diagnostic test) has been challenged through this year with delivery in June 2022 at 23.32%. This is driven mainly by imaging services (MRI, CT, non-obstetric ultrasound) and endoscopy.

Prioritising People's Mental Health and Wellbeing

There has been a sustained focus on expanding and improving mental health services and services for people with a learning disability and/or autism. We know, however, that Covid-19 has not only affected the delivery of services but has also caused an increase in demand particularly for psychological therapies, children and young people's services, severe mental health (SMI) physical health checks in primary care and perinatal mental health.

We saw an accelerated rollout of the two-hour crisis community health response to ensure consistent cover (8am-8pm, seven days a week) which has been achieved. North east London has also worked with local authority and community and mental health partners to achieve reductions in long stays and therefore free up capacity in acute settings.

Reported performance on mental health standards for June has remained challenged in some areas with under performance for IAPT (talking therapies) access and waiting times (both 14% under plan), Dementia diagnosis (7% under plan), SMI physical health checks, health checks for those with serious mental illness, (15% under plan) and children and young people's eating disorders (5% and 12% under plan). Children and young people's access and perinatal access has been narrowly achieved and early intervention in psychosis was compliant.

Face to face IAPT services have been reinstated, and are supported by virtual offers which enable improved access and give service users more options in how they are supported. Children and young people's services have also had new digital offers including a primary care network pilot, as well as 'mental health in schools' teams being expanded. Perinatal access has additional funding identified in order to recruit additional staff.

Sustainable Development

We are committed to promoting environmental and social sustainability through our actions as a corporate body and commissioner. Our procurement strategy requires us to consider our providers' approaches to sustainability and carbon management. As part of our responsibility to the Social Value Act, we will consider local providers for our services and suppliers of goods, given the associated benefits for low emissions, local job creation and local business prosperity. This also supports CCG and system spending within north east London and can deliver wider local social and economic benefits. Over the past year we have largely worked remotely, which has reduced staff travel and use of consumables. We have developed and increased our ability to hold our meetings virtually, and this is set to continue through a more flexible approach for the foreseeable future.

Our IT and primary care colleagues have supported general practice to transform the way that primary care services are delivered, with far more patient consultations taking place online therefore reducing

patient travel to appointments. Following the receipt of a recommendations report on sustainable development for NEL CCG in March 2021 we have responded to this by allocating staff to lead on net zero implementation. In February 2022 we recruited five Net Zero Clinical Leads to oversee the input from Primary Care. In March 2022, we completed a series of workshops with system partners to create a NEL Integrated Care System (ICS) Green Plan as mandated by NHS England.

Our staff continue to be engaged on reducing the environmental impact of the ICB via a staff green team. We have formed net zero networks that link staff and leaders across the system to deliver on the aims of the Green Plan to reduce our carbon footprint by 40% by 2025. We have begun to deliver year one of the Plan and work closely with local partners and regional teams to transform integrated local services to become more sustainable services via active travel projects, increasing the use of low carbon medicines and by hosting training events.

The NEL ICS Green Plan is available on the [North East London Health and Care Partnership website](#).

Improve quality

Improving the quality of local health and care services is central to everything we do in north east London. We continuously review and evaluate GP, hospital, mental health and community services to make sure they are as safe and effective as possible so that everyone, whatever their individual needs, has a good experience and easy access to excellent local services.

Last year we reported on the NHS Patient Safety Strategy which was launched in 2019 and required all CCGs and NHS Trusts to appoint a patient safety specialist with a direct line of accountability to the Board. We have created a network of all the patient safety specialists appointed by local Trusts and we are now working with them to develop and implement a new system to learn from patient safety events and improve the safety of local services.

We have also set up a new 'System Quality Group' to cover the whole of north east London which brings together the CCG, and quality leads from all the local Trusts so we can look at wider system issues as well as focussing on issues that are specific to each borough via our new borough-based arrangements – which have been developed in preparation for the move from a CCG to ICB.

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

There has been preparation for the move to an ICB with discussions across our system and through local places and provider collaboratives. The way quality improvement will operate at place, within a systems framework, is being developed through quality forums aligned to each place partnership was supported by the CCG. Place partnerships are where the NHS, local authorities, and the voluntary and community sector integrate delivery, supporting seamless and joined up care and where we will most

effectively tackle many health inequalities through prevention, early intervention, and community development, including at neighbourhood level. This model can generate rich insight into residents' views including of quality and help us to build a detailed understanding of where we need to focus our resources.

Improvement highlights in Barking and Dagenham, Havering and Redbridge

The BHR Quality and Performance Oversight Group continued its approach to quality assurance and improvement, with a focus on real system issues across Barking and Dagenham, Havering and Redbridge (BHR) with partners working collaboratively to identify and agree actions to make improvements.

Additional Infection Prevention and Control (IPC) advice and support for care/nursing homes and social care such as supported living and day care across BHR continued throughout this period.

Following the CQC inspection of the emergency department at Barking, Havering and Redbridge University Hospitals Trust (BHRUT) a 128-point system action plan was developed. This process has since been completed following a system review with assurances that all actions had been carried out.

Borough based quality conversations took place, with a focus on health inequalities and areas of concern as identified at place. Development of place based quality forums has begun with the quality team working closely with local system partners on agreeing the approach.

Improvement highlights in Tower Hamlets, Newham and Waltham Forest

We have continued to develop new arrangements for quality improvement in Tower Hamlets, Newham and Waltham Forest by developing a borough-based approach to quality assurance and improvements. Some highlights for April to June 2022/23 have been highlighted below:

- Improving the quality and safety of discharges from Barts Health, Royal London, to home care agencies and homeless hostels, working with local authority commissioning managers, hospital social work teams, integrated discharge hub and hospital leads.
- Quality support for Tower Hamlets, Newham and Waltham Forest (TNW) Cancer Board, piloting a new approach to GP service alerts, engaging with the commissioning managers and hospital service leads, resulting in new paediatric pathways being developed, changes to referral pathways and working on urgent cancer referral processes.
- Quality support to developing joint safety incident review processes with organisations across patient pathways to adequately address interfaces where risk increases, using two incidents as a pilot. Learning included how we involve safeguarding colleagues, primary care, information governance and executive sign-off of incident investigation findings and recommendations that span multiple organisations.

Improvement highlights in City and Hackney

We continued to develop our neighbourhood arrangements in the City of London and Hackney by strengthening our multi-disciplinary teams and neighbourhood offices. Our new community navigators based in the neighbourhood teams are working with primary care networks and are now having a real impact on supporting our most vulnerable residents to get the care they need.

The City and Hackney Quality and Outcomes Group brings together Homerton Healthcare FT, East London Foundation Trust, GPs, two Healthwatch organisations and our two local authorities and has been working on identifying a number of quality priorities for our local partnership.

We have been investing in GP services locally and supporting practices to develop 'virtual wards' to care for people at home but with additional services to keep them safe and avoid an unnecessary trip to hospital. All our GP practices are currently rated either Outstanding or Good by the Care Quality Commission and GPs get very positive feedback via the national GP patient survey.

Engaging people and communities

As a CCG with a rapidly-growing population that continues to face considerable health inequalities, particularly evident during the pandemic, we remain committed to placing patients and the public at the heart of the work we do, to transform and sustain services locally through genuine and effective participation.

- Our participation strategy, 'Working with people and communities', was submitted to NHS England with positive feedback received. This was co-created with the NEL CCG Participation and Engagement Working Group which is made up of engagement colleagues from across the system, as well as from local people – the strategy built on the good work already happening at place and within our provider collaboratives rather than starting from scratch. In April over 50 people attended five focus groups to input into the development of the NEL ICS standards for participation and a NEL Citizens' panel survey also asked local people their views which fed into the strategy.
- A key part of the engagement approach under discussion was how to engage with local people and patients at a borough or 'place' level - on how we truly integrate care. The new place-based partnerships involve all parts of the NHS with the local authority and voluntary sector including Healthwatch working together in an increasingly joined up way to improve health and wellbeing and reduce health inequalities. Each are developing and building on local resident participation arrangements.
- To help establish an effective place-based engagement model, the City and Hackney team carried out a review that aimed to map the current engagement landscape and how accessible and equitable that is. The review also looks at what changes are needed in order for local

residents to be able to meaningfully engage in collective decision making as well as look after their own health and wellbeing. A comprehensive equality impact assessment was carried out as part of the review, including survey with local residents and interview with local organisations. The review is expected to be completed in November 2022.

- In June 2022 we also supported the primary care networks (PCNs) across NEL by preparing an engagement toolkit which was designed to help PCNs hear and understand the views from residents on the plans for primary care services - the 'enhanced Primary Care DES'. Over 38,000 thousand responses were received and considered.
- Working with NHS, local authority and third sector partners we continued to reach our vulnerable communities while planning for the winter vaccinations (Covid boosters and flu vaccinations) push from September. We are currently allocating funding to local authority and community partners to continue outreach work with specific communities, including homeless people.
- We provided new information leaflets and campaign materials, including videos and easy read documents, to GP practices and local people on regarding long Covid. Specific information to support our homeless community was created and we attended the GP training session to discuss resources available and our engagement approach.
- The BHR planned care team have been working on shaping and co-designing a new model for community-based diabetes services. Across April and May 2022, people who live with diabetes in Barking and Dagenham, Redbridge and Havering took part in engagement activities about current services and considered what could be done to improve them. This was carried out through a survey (386 completed), series of four focus groups (34 attendees) and a co-production event with clinicians.
- Local authorities and voluntary organisations shared resources and held events across NEL to support Ukrainian people seeking refuge from the war - and those volunteering to host them. We supported this by providing help and guidance around registering for a GP and how to use the NHS. Local GPs attended the events to give advice and Doctors of the World information in relevant languages was given out.
- In City and Hackney, the team produced a health services directory that was translated to Ukrainian and Russian and shared with families and organisations supporting people arriving from Ukraine.
- We continue to work with Maternity Voice Partnerships and community-based services who support pregnant people, to ensure we understand, and work to improve maternity experiences for all our communities. This year we will produce a maternity equity and equality action plan, working with Healthwatch across all places to engage with maternity service users and their

advocates. The outcomes will inform actions to improve outcomes for pregnant people from ethnic minority backgrounds and those living in the most deprived areas.

- A 10-week public engagement period launched on 13 June 2022 to seek feedback and views on our proposed changes to the existing fertility policies, which detail the NHS support to help to try to have a baby. The proposals aimed to remove current inequities across north east London and to create one single policy. Through the process views were sought from all stakeholders and communities, but particularly from those with experience of fertility services. The policy will be fairer, closer to the latest national guidelines and in line with best practice. It also recognises the variety of fertility situations and needs today.
- Children and young people continue to be involved in co-production of services, including programmes such as Health Spot, Head Start and Youth Health Champions. Our young people's mental health conference, '*All About Me, For The Benefit Of Everyone*', saw young people taking the lead to share what is working and what needs fixing.
- The East London Women's Experience Forum continues to meet monthly, providing an opportunity for those pregnant and their families or people planning pregnancy to ask questions and seek information and advice from senior midwives across NEL.
- The NHSEI Core20PLUS Connectors Havering programme has commenced with the first steering group held in May, consisting of members from Havering council and local voluntary and community organisations. A post of local area co-ordinator is being established, a role which includes recruiting other community connectors who act as a voice for the local community, focussing on barriers and enablers to reduce health inequalities and connect service users with decision-makers. Building on existing work already carried out locally, work is underway to ensure that the role of the local area co-ordinator and community connectors is understood in the context of existing community/health champions.
- An in-depth programme of engagement was launched around end-of-life services and support across Waltham Forest and Redbridge – linked to the development plans for Whipps Cross Hospital. A sensitive approach was piloted – starting with independent one-to-one interviews with people with a life-limiting condition, receiving end-of-life care or in bereavement – including with people and communities needing culturally specific support at this challenging time.
- We continue to make use of the NEL Citizen's Panel. The panel is designed to make it easy for people to give virtual feedback on local health and care topics, and for those not able to attend more formal meetings to have their say. Using a phone or computer, at a time that suits them, members are able to tell us their thoughts on ideas or proposals, or give feedback or suggestions on health and care issues or topics through short surveys.

- We have continued to work closely with our local Healthwatch and in planning and developing our new system arrangements as we establish the Integrated Care Board from July, Healthwatch representatives will sit on our Integrated Care Partnership (ICP) Steering Committee, wider ICP, Place Partnership Boards with a representative at the ICB Board.

In addition to our engagement through social media, local project liaison and newsletters we continue to engage with key stakeholders through regular meetings e.g. with Healthwatch, with MPs and health overview and scrutiny committees and joint health overview and scrutiny committees.

Reducing health inequality

People's chances of enjoying good health and a longer life are not equal. They are determined by the social and economic conditions into which they are born and live their lives (which also make a difference to the way people use health services and look after their own health). These different conditions create avoidable health inequalities, which can only be addressed through action across the whole of society.

There is widespread, collaborative action to tackle health inequalities at place level, close to local communities, across NEL. Local health and wellbeing strategies consider the changing health and social care needs of the population, as set out in the local joint strategic needs assessment (JSNA) and identifies key priorities, which then underpin service planning. Place-based partnerships bring together key health and care partners, and health inequalities will be a key consideration as they develop their local outcome frameworks.

Recognising and building on delivery and expertise at the local level, a NEL Population Health and Health Inequalities Steering Group provides strategic leadership to embed population health and health equity across all parts of the system. The steering group oversees four workstreams: population health management; equity in health and care services; embedding prevention; and anchor system. The approach includes activity against the five health inequalities priorities of the NHS Operating Plan and the Core20Plus5 (the approach defines a target population cohort - the 'Core20PLUS' - and identifies '5' focus clinical areas requiring accelerated improvement).

Improving population health and reducing inequalities is core to our strategy as an ICS, and we are committed to addressing inequalities across all of our workstreams and services.

Some examples of our achievements so far include:

- Analysis of trust elective waiting lists resulting in successful actions to reduce inequalities in waiting times experienced by people with a learning disability.
- Reducing vaccine inequalities, through data analysis, hyperlocal interventions and outreach.
- NEL anchor charter and collaborative action, e.g. Health and Employment Hub supporting 750 underrepresented local people into work.

- Developing understanding of the health needs of our population through the NEL population health profile, and developing capability and capacity to address these through our Population Health Management programme.
- Mobilising tobacco dependence services and alcohol care teams in our hospitals.
- All Primary Care Networks have developed and are currently implementing and monitoring plans on how they will address health inequalities experienced by a defined cohort of their population.

Health and wellbeing strategy

Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which the local health and care system could work together to improve the health and wellbeing of their local population.

In addition to a continued local focus, health and wellbeing board and elected leaders have continued to work together with NHS leaders and partners to discuss our collective plans and development as an integrated care system. Together we agreed our plans for establishing a wide and inclusive Integrated Care Partnership, with a 'steering group' to steer the programme of activity and development of a new Integrated Care Strategy for NEL for 2022/23. The strategy will be developed with insight from all local joint strategic needs assessments (JSNAs) and in line with the priorities identified within local health and wellbeing strategies. Healthwatch organisations continue to gather valuable resident insight across health and care, plus data on the wider determinants of health. This information will influence the development of the strategy.

Partners have worked together to further develop their place based partnerships, with the additional element of an ICB sub-committee from 1 July to enable delegation and decision making close to people, with key partners as full members. Each place based partnership and sub-committee worked closely with health and wellbeing board members and leaders to ensure alignment of priorities locally – with strengthened resident participation and voluntary/community sector voice central to our approach.

Financial review

Going concern opinion

As at 30 June 2022 the CCG had net liabilities of £307.9m (£366.6m as at 31 March 2022).

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going

concern for the final set of financial statements. If services will continue to be provided the CCG is a going concern and the financial statements are prepared on the going concern basis.

Following the approval of the Health and Care Bill on 28 April 2022 NHS North East London CCG was dissolved on 30 June 2022. Whilst the CCG as an entity ceased to exist on that date, the activities undertaken by the CCG continued to be undertaken by NHS North East London Integrated Care Board. In accordance with the Department of Health and Social Care Group Accounting Manual, the continuation of the provision of services within the public sector means that the accounts of the CCG were prepared on a going concern basis.

The budget for 2022/23 has already been agreed with NHSE. On this basis, there is no reason to believe that sufficient funding will not be made available in the 9 months from the date of approval of these Financial Statements.

Financial performance

In Q1 2022/23 NHS North East London CCG was given funding of £986.4m from NHSE. Within this funding the CCG is allowed to spend £10.2m on the running costs of the organisation.

The majority of the CCG's spend is used to purchase services from NHS Trusts and NHS Foundation Trusts. In Q1 2022/23 we spent £686.8m (£2,742.8m in 2021/22), which is 69% (69% in 2021/22) of our total spend.

The CCG delivered a breakeven position for Q1 2022/23. The CCG has also remained within the running costs allocation.

The financial position continues to be very difficult throughout the remainder of 2022/23 for which the ICB will be responsible. The CCG and future ICB are working collaboratively with partners across the system to deliver the actions and mitigations required in relation to the challenging financial position.

The financial statements contained within the report provide a summary of the CCG's financial position and performance for Q1 2022/23. This section of the report talks about how we manage our money and how our financial performance is measured.

We are accountable for how we spend public money and achieve good value for money for our patients. This is the final quarter of North East London CCG, and good financial control and management is vital for the development of the organisation as we transition to North East London Integrated Care Board.

Funding

In Q1 2022/23 North East London CCG was given funding of £986.4m from NHSE. Within this funding the CCG is allowed to spend £10.2m on the running costs of the organisation.

How we spent the money

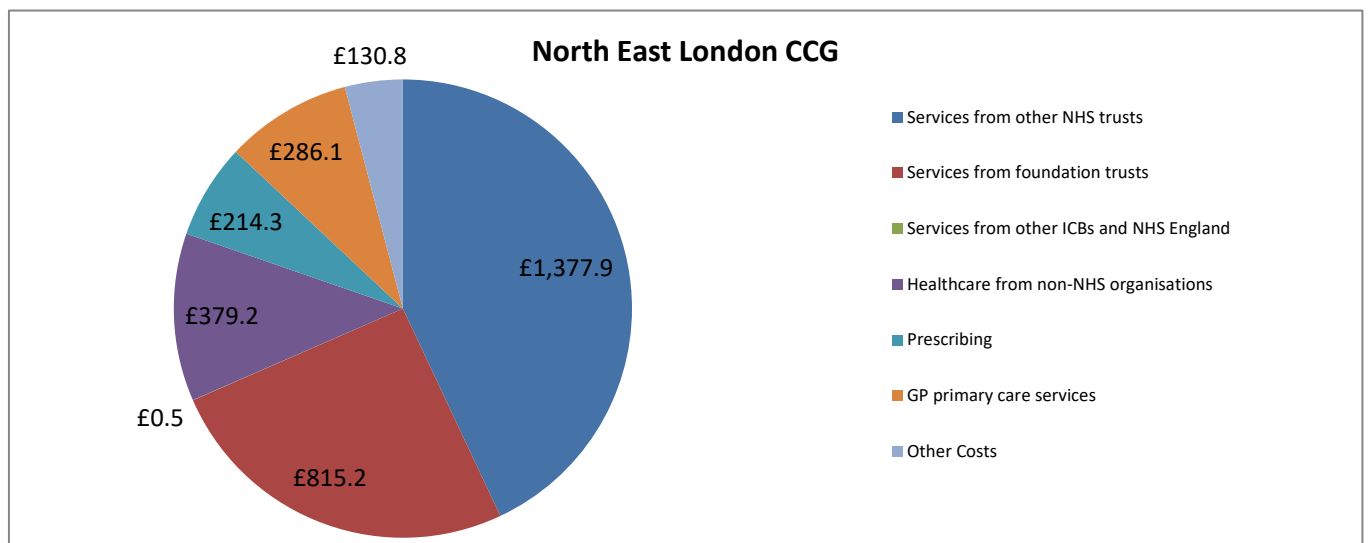
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In Q1 2022/23, spend related to delegated co-commissioning arrangements totalled £90.3m (£350.8m in 2021/22). This equates to 9% of total spend (9% in 2021/22.)

In summary we spent the money as follows:

| | £'000 | % |
|--|---------------------|--------|
| Services from other NHS trusts | 1,378 | 43.0% |
| Services from foundation trusts | 815 | 25.4% |
| Services from other CCGs and NHS England | 1 | 0.0% |
| Healthcare from non-NHS organisations | 379 | 11.8% |
| Prescribing | 214 | 6.7% |
| GP primary care services | 286 | 8.9% |
| Other Costs | <u>131</u> | 4.1% |
| | <u>3,204</u> | 100.0% |

A.1: How we spent the money



Overall Financial Performance

During Q1 2022/23 NEL CCG has worked under revised financial arrangements in response to the pandemic. The arrangements included block contracts with NHS providers, specific funding for COVID 19 services and a greater emphasis on financial planning at an Integrated Care System level.

The CCG delivered a breakeven position in Q1 2022/23. The CCG has also remained within the running costs allocation.

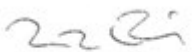
Financial pressures

The CCG has faced a range of financial challenges across the year mainly impacted by the response to COVID 19 including; Continuing Health Care (CHC), Hospital Discharge Pathway and Independent Sector Contracts.

Future years

Regulators have confirmed the NHS has a fixed level of CCG funding for the financial year 2022/23 which will cover the locally agreed and NHSE set block contract values for NHS providers.

ACCOUNTABILITY REPORT



Zina Etheridge

Accountable Officer

5 October 2022

Corporate Governance Report

The purpose of the corporate governance report is to explain the composition and organisation of the CCG's governance structure and how they support the achievement of our objectives.

Members Report

Member profiles

Our former website gives more details about our [governing body, including profiles of members](#).

Member practices

During quarter one of 2022/23, the CCG's membership comprised of 275 GP practices. The full list of practices is available on our former [website](#).

Composition of Governing Body

The CCG Governing Body (GB) was comprised of clinical chairs, appointed members and officers who have the duty to ensure the CCG exercises its functions effectively, efficiently and economically. The GB was responsible for ensuring that the CCG met all its financial obligations, including accounting and auditing and performing its functions in a way which provided good value for money.

The members are detailed below and more information about the GB and its work is contained in the Governance Statement.

| Name | Title and/or role |
|------------------------------|--|
| Dr Jagan John | CCG Chair and Clinical Chair Barking and Dagenham |
| Zina Etheridge | Accountable Officer |
| Sue Evans | Deputy CCG Chair and Lay Member Primary Care |
| Professor Sir Sam Everington | Deputy Clinical CCG Chair and Clinical Chair Tower Hamlets |
| Dr Mark Ricketts | Clinical Chair City and Hackney |
| Dr Atul Aggarwal | Clinical Chair Havering |
| Dr Muhammad Waqqas Naqvi | Clinical Chair Newham |

| Name | Title and/or role |
|--------------------|--|
| Dr Anil Mehta | Clinical Chair Redbridge |
| Dr Ken Aswani | Clinical Chair Waltham Forest |
| Kash Pandya | Lay Member Governance |
| Noah Curthoys | Lay Member Performance |
| Khalil Ali | Lay Member Patient and Public Involvement |
| Fiona Smith | Independent Clinical Member – Registered Nurse |
| Charlotte Harrison | Independent Clinical Member – Secondary Care Clinician |
| Henry Black | Chief Finance Officer |

Meetings were also attended regularly by the following members of staff who are not voting members of the governing body, but are part of the CCG's senior management team:

| Name | Role |
|------------------|-------------------------------------|
| Archna Mathur | Director, Performance and Assurance |
| Diane Jones | Chief Nurse |
| Marie Price | Director, Corporate Affairs |
| Siobhan Harper | Director, Transformation, TNW |
| Ceri Jacob | Managing Director, BHR |
| Rachel Patterson | Director, People and OD |
| Steve Collins | Executive Director, Finance |

Committee(s), including Audit Committee

The CCG's Audit and Risk Committee members are detailed below and more information about the committee and its work is contained in the Governance Statement.

Audit and Risk Committee

| Name of member | Role |
|--------------------|--|
| Kash Pandya | Lay Member Governance (Chair of the committee) |
| Noah Curthoys | Lay Member Performance (Deputy Chair of the committee) |
| Sue Evans | Lay Member Primary Care |
| Khalil Ali | Lay Member Patient and Public Involvement |
| Charlotte Harrison | Independent Clinical Member – Secondary Care Clinician |

Details of membership of other committees is also contained in the Governance Statement.

Register of Interests

The CCG published a register of members' and senior managers' interests on the [website](#) which was updated as and when changes were notified to the CCG. The register gives details of company directorships or other significant interests held by members and senior managers where those companies were likely to do business, or possibly seek to do business with the NHS, where this may conflict with their managerial responsibilities.

Personal data related incidents

The NHS Information Governance (IG) Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The framework is supported by an IG toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust IG systems and processes in place to help protect patient and corporate information. We have established an IG management framework and have implemented IG processes and procedures in line with the IG toolkit. We ensure all staff undertake annual IG training and have provided staff with guidance on their IG roles and responsibilities.

We use local clinical and corporate incident management and reporting tools to record and report incidents and record all internal incidents. We notify the Department of Health and Social Care and the Information Commissioner's Office (ICO) of serious incidents that require investigation via the national IG incident reporting tool.

During the reporting period, the CCG had no serious incidents involving data loss or confidentiality breaches that require formal reporting to the ICO.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report.
- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

NEL CCG fully supported the Government's objectives to eradicate modern slavery and human trafficking and meets the requirements for producing an annual 'Slavery and Human Trafficking Statement' as set out in the Modern Slavery Act 2015. The statement can be found on the [website](#).

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Zina Etheridge to be the Accountable Officer of NEL CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money

- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section 14R of the National Health Service Act 2006 (as amended))
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).
- Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer between April and June 2022, I have taken all the steps that I ought to have to make myself aware of any relevant audit information and to establish that NEL CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware. I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

Governance Statement

Introduction and context

NHS North East London CCG is a body corporate established by NHS England on 1 April 2021 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

During this reporting period the clinical commissioning group was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I had responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I was responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also had responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it. This has been achieved through the following means:

The Constitution

The Constitution, which was approved by NHSE as part of the authorisation process in March 2021 provides that it is the GB which undertakes any functions not reserved or otherwise delegated.

The scheme of delegation included in the constitution sets out those specific decisions that are reserved for the Members' Committee. These are as follows:

- Make recommendations to NHS England for changes to the Constitution of the Group.
- Amending the Standing Orders and/or the Scheme of Delegation.
- Change the nature of the business of the Group or do anything inconsistent with the mission, values and aims of the Group.
- Use any other name than that specified in Clause 1.1 of the Constitution in relation to the activities of the Group.
- Merge, amalgamate or federate the Group with any other CCG.
- Seek to remove any Member.
- Reorganise the boundaries of or change the organisational structure of the Group.
- Approve the arrangements for appointing and removing Clinical Chairs to/from the GB.

CCG governance structure

The CCG governance structure was created to ensure that clinicians and patients were at the heart of decision making whilst delivering on the strategic objectives agreed by the GB at the start of the year. The governance structure reflects the fact that there is a shared management team and operating model supporting three local integrated care partnerships (ICPs) whilst maintaining the functions of the CCG in its own right as a statutory body with overall accountability.

Governing Body

Meetings were held online on Microsoft Teams. Members of the public were invited to join virtually and, as always, to submit questions in advance and recordings of the meetings were made available via the CCG's website.

The key areas of focus for the Governing Body at the meetings held between April and June 2022 were:

- a. Maternity services following the Ockenden review
- b. Emergency preparedness, resilience and response
- c. CCG transition to an Integrated Care System and due diligence
- d. Assurance – to keep sight of current issues and assurance provided that risks in relation to the pandemic were being managed
- e. Reporting on finance and activity information from commissioned health providers
- f. Reporting on and oversight of CCG finances

- g. Reporting on and oversight of performance and quality issues within commissioned health providers
- h. Reporting on patient and public engagement in the work of the CCG
- i. The management of strategic risk through scrutiny of the Governing Body Assurance Framework (GBAF)
- j. Compliance with CCG statutory duties
- k. Minutes and reports from the committees of the Governing Body and working groups where appropriate.

Governing Body effectiveness review

Comments were received from GB members on what they felt had gone well this quarter and what could be improved going forward as an ICB.

Things that went well:

- Good opportunities for open discussions and debate.
- Reports are clear and provide the necessary level of assurance.

Areas for improvement:

- Encourage more input from patients.
- Ensure members of the public ask questions relevant to the agenda

The membership and attendance record of the Governing Body is outlined in the table below:

| Governing Body members | 25 May 2022 | 16 June 2022 | 29 June 2022 | Total attended /total possible |
|-------------------------------|--------------------|---------------------|---------------------|---------------------------------------|
| Dr Jagan John | ✓ | ✓ | ✓ | 3/3 |
| Zina Etheridge | ✓ | ✓ | ✓ | 3/3 |
| Henry Black | ✓ | ✓ | ✓ | 3/3 |
| Dr Atul Aggarwal | X | ✓ | ✓ | 2/3 |
| Khalil Ali | ✓ | ✓ | ✓ | 3/3 |

| | | | | |
|------------------------------|---|---|---|-----|
| Dr Ken Aswani | ✓ | ✓ | ✓ | 3/3 |
| Noah Curthoys | ✓ | ✓ | ✓ | 3/3 |
| Sue Evans | ✓ | X | ✓ | 2/3 |
| Professor Sir Sam Everington | ✓ | X | X | 1/3 |
| Charlotte Harrison | ✓ | ✓ | ✓ | 3/3 |
| Dr Anil Mehta | ✓ | ✓ | ✓ | 3/3 |
| Dr Muhammad Naqvi | ✓ | ✓ | ✓ | 3/3 |
| Kash Pandya | ✓ | ✓ | ✓ | 3/3 |
| Dr Mark Rickets | ✓ | ✓ | ✓ | 3/3 |
| Fiona Smith | ✓ | ✓ | ✓ | 3/3 |

The meeting was also attended regularly by:

- Archana Mathur – Director, performance and Assurance
- Diane Jones - Chief Nurse
- Marie Price – Director, Corporate Affairs
- Steve Collins – Executive Director, Finance
- Anne-Marie Keliris – Head of Governance
- Siobhan Harper – Director, Transformation, TNW
- Ceri Jacob – Managing Director, BHR ICP
- Nina Griffiths – Director of Delivery Development, C&H (from March 2022)
- Rachel Patterson – Director, People and OD
- Laura Anstey – Chief of Staff

Committees of the Governing Body

The GB had authority under the scheme of delegation to establish committees or sub groups to enable it to fulfil its role. Each of the GB committees had terms of reference and the roles of each are set out broadly below. Each committee was authorised by the GB to pursue any activity within their terms of reference and within the scheme of reservation and delegation of powers.

Audit and Risk Committee

The committee was established in accordance with the CCG's constitution and reported directly to the Governing Body. The Committee provided assurance and advice to the Governing Body and to the Accountable Officer on:

- The proper stewardship of resources and assets including value for money.
- Financial reporting.
- The effectiveness of audit arrangements (internal and external).
- Risk management.
- Control and integrated governance arrangements within the CCG.

Committee effectiveness review

Members were asked to review the Committee's work for the quarter and list what has gone well and whether there were any gaps in assurance.

Things that went well:

- Respectful tone set by Chair enabling challenging conversation within a supportive atmosphere.
- Strong focus on ICB/ICS readiness.

Areas for improvement:

- As an ICB committee, in future the Audit Committee will need a wider, more strategic view.
- Increased view of risk at an ICS level.

The membership and attendance record of the Audit and Risk Committee is outlined below:

| Audit & Risk Committee members | 21 April 2022 | 15 June 2022 | Total attended /total possible |
|--------------------------------|---------------|--------------|--------------------------------|
| Kash Pandya (Chair) | ✓ | ✓ | 2/2 |
| Charlotte Harrison | ✓ | ✓ | 2/2 |
| Sue Evans | ✓ | ✓ | 2/2 |
| Noah Curthoys | X | ✓ | 1/2 |

| | | | |
|------------|---|---|-----|
| Khalil Ali | ✓ | ✓ | 2/2 |
|------------|---|---|-----|

The meeting was also regularly attended by:

- Henry Black – Chief Finance Officer
- Steve Collins - Executive Director, Finance
- Sunil Thacker – Director of Finance, TNW
- Ahmet Koray – Director of Finance, BHR
- Marie Price – Director of Corporate Affairs
- Dean Gibbs/Carl van den Berg – External Auditor, KPMG
- Nick Atkinson/John Elbake – Internal Auditor, RSM
- Mark Kidd – Local Counter Fraud Services, RSM

The CCG directors attended meetings to outline their directorate’s current highest areas of risk and the mitigations in place to demonstrate effective risk management and allow the Committee to keep abreast of emerging risks and offer support.

The GB had other committees that have a monitoring and oversight role and Audit and Risk Committee members who attended other committees so able to feedback and make linkages which strengthened the committee’s role.

The committee held its meetings remotely using MS Teams. All meetings were quorate and the minutes of each meeting, once agreed, were presented to the GB with a summary report from the Chair highlighting key issues and advising the GB of emerging risks.

The Audit and Risk Committee’s work in April – June 22

This annual report summarises the work undertaken during the year and is divided into a number of sections that reflect the key duties of the Committee as set out in the terms of reference.

Governance, risk management and internal control

The workplan for the Audit and Risk Committee was kept under review and altered where appropriate to respond to the emerging Covid-19 pandemic and the close down of NEL CCG ahead of the move to an Integrated Care Board.

The Committee established underlying assurance processes that indicate the degree to which the CCG’s objectives were achieved. In year, the Committee reviewed the GB Assurance Framework (GBAF) and members were assured that the framework used was fit for purpose. The Committee also considered the corporate risk register updates and is of the opinion that

adequate systems for risk management were in place ahead of the move to an ICB and ICS in the coming financial year.

Internal Audit

RSM provided the internal audit service this quarter. The Committee worked effectively with internal audit to strengthen the CCG's internal control processes. This included private meetings with RSM to seek assurances about the effectiveness of the internal audit service.

The Committee considered the findings of the internal audit reports and was assured that management had responded in an appropriate and timely manner. The Committee regularly followed up on the recommendations auditors made to management to ensure they were being implemented.

In September 2022, internal audit concluded in their draft Head of Internal Audit Opinion for 1 April – 30 June 2022 that the organisation had an adequate and effective framework for risk management, governance, and internal control, though there were opportunities to strengthen controls in some areas. The ICB's Audit and Risk Committee will continue to ensure that these control enhancements are put in place.

Financial reporting

In line with its terms of reference, the Committee reviewed aspects of the CCG's financial management, internal controls and financial reporting. Updates were provided on the CCG's financial position, escalated risks and the mitigating actions put in place. At the time of writing, the final draft financial statement is to be presented to the ICB's Audit and Risk Committee at its meeting in September 2022 prior to gaining Board approval at its meeting in September 2022.

Ensuring probity

The Audit and Risk Committee kept under review the arrangements in place for ensuring probity in the conduct of business by the CCG, as described in the Committee's terms of reference.

As previously mentioned, following each Committee meeting, the Chair provided a feedback report to the GB to accompany the minutes to cover its duty in providing the GB with assurances that effective internal control arrangements are in place. These reports are available on the CCG's former website within the GB papers.

NEL Quality, Safety and Improvement Committee

The NEL Quality, Safety and Improvement Committee was a committee of the GB. It examines and reports on the quality of clinical services across NEL. The Committee also covered assurance of internal governance and quality standards where the CCG had responsibility for regulatory standards and statutory requirements and an oversight of quality across the NEL system.

The duties of the Committee were to:

- Have oversight of any system-wide quality and safety objectives.
- Oversight of quality and safety risks on the GBAF and agree any action for improvement.
- Receive updates on changes to national policy and gain assurance that these have been appropriately adopted by the relevant organisation within the system.
- Receive performance data on services and review trend and themes data from across the system and to seek assurance on actions when there is an impact on quality.
- Oversee the delivery against safeguarding, infection control, complaints and approve CCG statutory reports relating to these.
- Review relevant audit reports and monitor or act on recommendations.
- Receive exception reports from subcommittees of the Quality Committee.
- Oversight of wider ICS improvement and transformation plans/programmes that propose to improve quality of services/pathways and patient experience and reduce health inequalities across NEL.
- Oversee appropriate assurance and governance in place for system assurance.
- Have a collective view of risks to quality through sharing relevant information, data and intelligence, to understand emerging concerns and risks across providers and the system.
- Oversee the patient experience agenda through complaints status, surveys, etc.
- Ensure the patient voice is heard across all quality, safety and improvement matters and that patient involvement is the norm in all quality improvement work.
- Review the quality impact assessment process during procurements and contract agreements and when reviewing any business cases.
- Review relevant audit reports and monitor or act on recommendations.
- Approve quality account statements for providers.
- Have an oversight of the quality of primary care and understanding how primary care improvement programmes are driving up the quality of primary care.

Committee effectiveness review

Comments were received from members on what they felt had gone well this quarter and what could be improved.

Things that went well:

- Preparation for the transition to an ICB.
- Covered a wide range of topics and equity of quality focus across the system.

Areas for improvement:

- Oversight of quality implications of poor performance.
- Forward planning for place reporting.

The membership and attendance record of the NEL Quality, Safety and Improvement Committee is outlined in the table below:

| Name of Committee member | 11 May 2022 | 15 Jun 2022 | Total attended /total possible |
|--------------------------|-------------|-------------|--------------------------------|
| Fiona Smith – Chair | ✓ | ✓ | 2/2 |
| Khalil Ali | ✓ | ✓ | 2/2 |
| Mark Gilbey-Cross | ✓ | X | 1/2 |
| Charlotte Harrison | ✓ | X | 1/2 |
| Archna Mathur | ✓ | X | 1/2 |
| Ceri Jacob | X | X | 0/2 |
| Jenny Singleton | ✓ | ✓ | 2/2 |
| Chetan Vyas | ✓ | ✓ | 2/2 |
| Jagan John | ✓ | ✓ | 2/2 |
| Alison Goodlad | X | X | 0/2 |
| Diane Jones | ✓ | X | 1/2 |
| Dawn Newman-Cooper | X | X | 0/2 |
| Korkor Ceasar | ✓ | ✓ | 2/2 |

The meeting was also attended regularly by:

- Helen O'Connor, Infection Prevention and Control Lead.

- Sandra Moore, Deputy Director of Continuing Healthcare (Interim), NEL.
- Jeanette Weismann, Quality Lead.

The Committee held its meetings remotely using MS Teams.

The following key topics were discussed by the Committee in between April and June 2022:

- Creation of a consolidated fertility policy across north east London.
- Maternity services following the Ockenden review
- Infection prevention and control
- Due diligence regarding CCG to ICS transition
- NEL Quality Risk register
- Quality report which included:
 - Provider oversight exception report
 - Borough updates
 - Safeguarding
 - Continuing health care (CHC)
 - Infection prevention control (IPC)
 - Patient safety
 - Serious incidents

Remuneration Committee

The NEL CCG Remuneration Committee made recommendations to the GB on determinations of the remuneration and conditions of service for all employees of the CCG, including salary, including any performance-related pay or bonus; provisions for other benefits, including pensions and cars and allowances under any pension scheme it might establish as an alternative to the NHS pension whilst adhering to the CCG's Standards of Business Conduct Policy, its Constitution, the good governance principles and relevant data.

Additional duties of the Committee were to:

1. Make recommendations on determinations of the remuneration and conditions of service for other individuals providing services to the CCG.
2. Make decisions on the remuneration and conditions of service of GB members and very senior managers (VSM) managers, subject to the exclusions set out in the Terms of Reference.

3. Consider and make recommendations on the severance payments of senior employees, seeking HM Treasury approval as appropriate in accordance with HM Treasury guidance;
 - Consider and make recommendations on the terms of settlement agreements for employees, before submission through the necessary approval process.
 - Make decisions on the severance payments and any settlement agreements relating to non-employed GB members.
 - Ensure processes are in place to monitor and evaluate the performance of GB members.
 - Ensure proper calculation and scrutiny of termination payments taking account of appropriate national guidance, advise on and oversee appropriate contractual arrangements for such staff.
 - Advise on and oversee appropriate contractual arrangements for staff, including redundancy arrangements in line with national or local contracts of employment and appropriate guidance or legislation.
 - Oversee the appointment or election process for GB members, and consider nominations and confirm changes to the membership of the Governing Body.
 - Develop an approach to succession planning for key GB members.
 - Set the terms of office for GB members, the performance review process for all GB members including the Chair of the Governing Body.

Committee effectiveness review

Comments were received from members on what they felt had gone well this quarter and what could be improved.

Things that went well:

- Committee members thought the meeting was well chaired, with papers available in a timely fashion with clear proposals and recommendations.
- Members appreciated the support, flexibility and membership.

Areas for improvement:

- Committee members felt that the changes in structure (both to senior leadership and the organisation) were presented in a more piecemeal than usual fashion, recognising impact of national timelines/restructure.

The membership and attendance record of the Remuneration Committee is outlined in the table below:

| Name of Committee member | 14 June 2022 | Total attended /total possible |
|--------------------------|--------------|--------------------------------|
| Dr Jagan John | ✓ | 1/1 |
| Noah Curthoys | ✓ | 1/1 |
| Sue Evans | ✓ | 1/1 |
| Khalil Ali | ✓ | 1/1 |

Other attendees with responsibilities within strategic and senior leadership, human resources and ICS development also attended, where appropriate.

The meeting was also attended by:

- Marie Gabriel, ICS Chair Designate
- Zina Etheridge, Accountable Officer
- Gareth Noble, Acting Associate Director of People

The Committee held its meeting remotely using MS Teams.

The following key topics were discussed by the Committee:

- ICS development updates
- Senior Leaders Job Description Amendments and Remuneration
- Proposed ICB Senior Leadership Arrangements
- Freedom to Speak Up

NEL Finance and Performance Committee

The NEL Finance and Performance Committee provided assurance to the GB on the robustness of the in-year financial strategy and financial management for the CCG. The Committee also receives assurance on the longer-term financial strategy and planning to ensure stability across NEL. The Committee was authorised to initiate investigation into any adverse activity or financial performance within its terms of reference. The Committee provided assurance to the GB on operational performance, as it relates to the Operational Planning guidance for acute and non-acute metrics and constitutional standards, as appropriate.

The duties of the Committee were to:

- Review and monitor the financial strategy and operational financial plans of the CCG and the current and forecast financial position of the overall CCG budget.

- Review and monitor system-wide operational performance in accordance with national operational planning guidance and advise on risks and mitigations.
- Oversee the arrangements for the delegation of budgets to the three ICP areas and ensure funds are allocated appropriately.
- Consider and review ongoing financial reports and the annual statement to be presented to the GB. Incorporating financial performance against budget, targets, financial risk analysis, forecasts, and statements on the rigor of underlying assumptions, to ensure statutory financial duties are met.
- Develop a performance framework that enables the Committee to review the financial performance and transformation agenda.
- Oversee implementation of investments/transformation schemes, receiving updates outlining financial activity and delivery against key performance indicators (KPIs) and outcomes for each scheme.
- Management of system risks to the CCG's financial performance and of plans to mitigate their impact.
- Providing assurance to the GB about delivery and sustained performance of contracts held by the CCG.
- Consider the benefits realisation of the merger into the CCG - including, but not limited to, the statutory transfer of contracts novation, use of estates and financial management and process.
- Consider and review any external financial monitoring returns and commentary.
- Review, and agree, pre-procurement decisions as appropriate, in accordance with prime financial policies and the scheme of delegation, and where required, make recommendations to the GB.
- Work alongside the Audit and Risk Committee to ensure financial probity in the organisation, and that value for money is reviewed and maintained.
- Review reports on the effectiveness of the business intelligence (BI) reporting platform and IT services.
- Review any capital plans being developed to ensure investment offers value for money across the ICS.
- Review and agree policies which relate to procurement and finance.
- Provide a report to the GB on how it discharges its responsibilities.

Committee effectiveness review

Comments were received from members on what they felt had gone well this quarter and what could be improved.

Things that went well:

- A practical approach to governance, management and assurance, given a new regime of financial allocation and a lot of changes.
- Focus on levelling up across NEL.

Areas for improvement:

- Gain from more deep dives and strategic papers, to review issues with more time, on a planned basis.
- Focus of recovery, strategy and delivery, rather than reporting with greater long-term planning.

The membership and attendance record of the Finance and Performance Committee is outlined in the table below:

| Name of Committee member | 27 Apr 2022 | 25 May 2022 | 29 Jun 2022 | Total attended /total possible |
|--------------------------|-------------|-------------|-------------|--------------------------------|
| Noah Curthoys (Chair) | ✓ | ✓ | ✓ | 3/3 |
| Henry Black | ✓ | ✓ | ✓ | 3/3 |
| Archna Mathur | ✓ | ✓ | ✓ | 3/3 |
| Fiona Smith | X | ✓ | ✓ | 2/3 |
| Kash Pandya | ✓ | ✓ | ✓ | 3/3 |
| Dr Ken Aswani | ✓ | ✓ | ✓ | 3/3 |
| Dr Sam Everington | X | X | X | 0/3 |

The AO was a member of the committee, however given the demands of transitioning to an ICB and establishing transitional ICB governance in preparation, deputising arrangements were put in place via CFO attendance.

GB members and/or CCG senior employees were invited to attend those meetings in which the Committee considered areas of risk or operation that are their responsibility.

The meeting was also attended regularly by:

- Steve Collins – Executive Director of Finance

- Ahmet Koray – Director of Finance, Barking, Havering and Redbridge ICP, NEL CCG
- Sunil Thakker – Director of Finance, City & Hackney ICP and Tower Hamlets, Newham and Waltham Forest ICP, NEL CCG

The Committee held its meetings remotely using MS Teams.

The following key topics were discussed by the Committee between April and June 2022:

- Monthly finance reporting, including finance management and risk
- CCG transition to ICS
- Performance Report
- Operating Plan
- Transformation
- Business cases

Primary Care Commissioning Committee

The CCG established the CCG's Primary Care Commissioning Committee to function as the decision-making body for the management of the delegated functions and exercise of delegated powers (for primary medical services). The Committee was accountable to both NHS England and the Governing Body, and responsible for ensuring all residents have access to GP services, and that GP practices deliver safe, high quality services to their patients.

The duties of the Committee were to:

- Make collective decisions related to primary care services in NEL under delegated authority from NHS England. This included:
 - Monitoring contracts, taking contractual action such as breach/remedial notices and removal of a contract.
 - Taking decisions on enhanced services.
 - Considering local incentive schemes and equalisation.
 - Agree the establishment of new GP practices within the area.
 - Make decisions on discretionary payments.
 - Approval of practice mergers.
- Work closely with each sub-committee to support it in the exercise of its delegated functions.

Committee effectiveness review

Comments were received from members on what they felt had gone well this quarter and what could be improved.

Things that went well:

- Executive expertise with strategic overview provided at meetings.

- Discussions had been held at place level prior to coming to the meeting for ratification.

Areas for improvement:

- Evidence of how variation and inequalities are being reduced across NEL primary care services.

The membership and attendance record of the Primary Care Commissioning Committee is outlined in the table below:

| Name of Committee member | 11 May 2022 | 30 Jun 2022 | Total attended/ total possible |
|--------------------------|-------------|----------------|--------------------------------|
| Sue Evans | ✓ | ✓ | 2/2 |
| Khalil Ali | ✓ | ✓ | 2/2 |
| Fiona Smith | X | ✓ | 1/2 |
| Charlotte Harrison | ✓ | ✓ | 2/2 |
| Henry Black | ✓ | ✓ ^D | 2/2 |
| Ceri Jacob | ✓ | ✓ ^D | 2/2 |

Audit Chair was member but non-attendance agreed on these two occasions.

The AO was a member of the committee, however given the demands of transitioning to an ICB and establishing transitional ICB governance in preparation, deputising arrangements were put in place via CFO attendance.

The meeting is regularly attended by:

- NEL and system directors of primary care
- Head of primary care
- Governing body chairs (x3)
- Independent GPs
- Healthwatch
- Local Medical Committees
- Local authority / public health representatives.

As part of the response to Covid-19, the Committee held its meetings remotely using Microsoft Teams.

The following key topics were discussed by the Committee between April and June 2022:

- Primary care budgets
- Primary care contracts
- Equalisation of Local Incentive Schemes (LIS)
- Enhanced service agreements
- Primary care premises
- Primary care performance
- Primary Care Network development
- Workforce issues
- Key risks

Barking and Dagenham, Havering and Redbridge Area Committee

The BHR Area Committee was established in order to enable the CCG to take decisions on the delegated functions within the Integrated Care Partnership Board (ICPB) structure, as permitted by law, and to enable, where necessary, commissioner only decision-making on the Reserved Functions in a simple and efficient way. The delegated and reserved functions are set out in the CCG's Scheme of Reservation and Delegation (SoRD).

The Area Committee met, along with system partners, as the Integrated Care Partnership Board (ICPB). All members of the ICPB can attend Area Committee meetings subject to the Committee operating within the CCG's governance framework and the management of actual and potential conflicts of interest. As attendees, they do not have a formal decision-making role in relation to the delegated functions but are encouraged to participate in discussions.

The duties of the Committee were to:

- Support the CCG in discharging its statutory financial duties, including through managing the budget delegated to it by the NEL CCG Governing Body.
- Provide assurance to the NEL CCG Governing Body.
- Have lead responsibility for the CCG's commissioning strategy in the ICP area.
- Have lead responsibility for population health management, supporting the CCG to discharge its statutory duties, including those relating to equality and inequality.
- Monitor performance in relation to quality and the improvement of services.
- Support stakeholder engagement and public involvement and consultation.

Committee effectiveness review

Comments were received from members on what they felt had gone well this quarter and what could be improved.

Things that went well:

- Good contributions by all stakeholders

Areas for improvement:

- Fewer agenda items to allow time for fuller discussion

The membership and attendance record of the BHR Area Committee is outlined in the table below:

| Name of Committee member | 26 May 2022 | Total attended /total possible |
|--------------------------|----------------|--------------------------------|
| Kash Pandya | ✓ | 1/1 |
| Zina Etheridge | ✓ | 1/1 |
| Henry Black | ✓ ^D | 1/1 |
| Jagan John | ✓ | 1/1 |
| Atul Aggarwal | ✓ ^D | 1/1 |
| Anil Mehta | ✓ | 1/1 |
| Ceri Jacob | ✓ | 1/1 |

The Area Committee was held in common with the BHR Integrated Care Partnership Board (ICPB). The BHR ICPB is a non-statutory partnership body that brings together representatives from across the BHR area to make decisions on policy matters relating to the BHR partnership and on matters that the member organisations have asked it to manage on its behalf.

The meeting was also attended by the following members of the ICPB:

- Cllr Maureen Worby, London Borough of Barking and Dagenham
- Rt Hon Jacqui Smith, Joint Chair, BHRUT and Barts Health
- Matthew Trainer, Chief Executive, BHRUT
- Jacqui Van Rossum, Acting Chief Executive Officer, NELFT
- Cllr Mark Santos, London Borough of Redbridge

- Cllr Jason Frost, London Borough of Havering
- Fiona Taylor, Interim Chief Executive Officer, London Borough of Barking and Dagenham
- Andrew Blake-Herbert, Chief Executive, London Borough of Havering
- Adrian Loades, Corporate Director of People, London Borough of Redbridge
- Dr Narendra Teotia, Primary Care Network Clinical Director, Barking and Dagenham
- Dr Gurmeet Singh, Primary Care Network Clinical Director, Havering
- Dr Sangeetha Pazhanisami, Primary Care Network Clinical Director, Redbridge

As part of the response to Covid-19, the Committee held its meetings remotely using MS Teams.

The following key topics were discussed by the Committee at its meeting in May 2022:

- Borough partnership
- Transformation programme
- BHR Health and Care Academy
- Finance
- Risk
- BHR Joint Strategic Needs Assessment

City and Hackney Area Committee

The City and Hackney Area Committee was established in order to enable the CCG to take decisions on the delegated functions within the Integrated Care Partnership Board (ICPB) structure, as permitted by law, and to enable, where necessary, commissioner only decision-making on the 'Reserved Functions' in a simple and efficient way. The delegated and reserved functions were set out in the CCG's Scheme of Reservation and Delegation (SoRD).

The Area Committee met, along with system partners from the London Borough of Hackney and the City of London Corporation as the Integrated Care Partnership Board (ICPB), formed as a committee-in-common.

The duties of the Committee were to:

- Support the CCG in discharging its statutory financial duties, including through managing the budget delegated to it by the NEL CCG Governing Body.
- Provide assurance to the NEL CCG Governing Body.
- Have lead responsibility for the CCG's commissioning strategy in the ICP area.

- Have lead responsibility for population health management, supporting the CCG to discharge its statutory duties, including those relating to equality and inequality.
- Monitor performance in relation to quality and the improvement of services
- Support stakeholder engagement and public involvement and consultation.

Committee effectiveness review

Comments were received from members on what they felt had gone well this quarter and what could be improved.

Things that went well:

- The Area Committee has met as part of the Partnership Board which has enabled a continuing development of the place-based partnership.

Areas for improvement:

- There is a need to properly articulate roles/remit/powers going forward and how these might develop.

The membership and attendance record of the City and Hackney Area Committee is outlined in the table below:

| Name of Committee member | 28 April 2022 | 12 May 2022 | 9 June 2022 | Total attended /total possible |
|--------------------------|---------------|-------------|-------------|--------------------------------|
| Mark Rickets | ✓ | ✓ | ✓ | 3/3 |
| Henry Black | ✓ | X | ✓ | 2/3 |
| Sunil Thakker | ✓ | ✓ | ✓ | 3/3 |
| Sue Evans | ✓ | ✓ | ✓ | 3/3 |

The AO was a member of the committee, however given the demands of transitioning to an ICB and establishing transitional ICB governance in preparation, deputising arrangements were put in place via CFO attendance.

The ICPB meeting is also attended regularly by:

- Cllr Chris Kennedy, Cabinet Member for Health, Adult Social Care and Leisure, London Borough of Hackney

- Deputy Mayor Antoinette Bramble Deputy Mayor and Cabinet Member for Education, Young People & Children's Social Care
- Cllr Rob Chapman, Cabinet Member for Finance, London Borough of Hackney
- Helen Fentimen, Member, Community and Children's Services Sub-Committee, City of London Corporation
- Ruby Sayed, Member, Community and Children's Services Sub-Committee, City of London Corporation
- Paul Calaminus, Chief Executive, East London NHS Foundation Trust
- Donna Kinnair, Non-Executive Director, East London NHS Foundation Trust
- Caroline Millar, Chair, City & Hackney GP Confederation
- Laura Sharpe, CEO, City & Hackney GP Confederation
- Catherine Macadam, Associate Lay member, NEL CCG
- Honor Rhodes, Associate Lay Member, NEL CCG
- Ann Sanders, Associate Lay Member, NEL CCG
- Dr Jenny Darkwah, Clinical Director, Primary Care Network
- Dr Haren Patel, Clinical Director, Primary Care Network
- Sir John Gieve, Chair, Homerton University Hospital NHS Foundation Trust
- Helen Woodland, Group Director Adults, Health & Integration, London Borough of Hackney
- Andrew Carter, Director, Community & Childrens' Services, City of London Corporation
- Simon Cribbens, Assistant Director, Commissioning and Partnerships, City of London Corporation
- Tony Wong, Chief Executive, Hackney Council for Voluntary Services
- Malcolm Alexander, Chair, Healthwatch Hackney
- Heather Ridge, Interim General Manager, Healthwatch City of London

The Committee held its meetings remotely using MS Teams.

The following key topics were discussed by the Committee in between April and June 2022:

- Financial and risk overview
- Integrated delivery plan
- Business cases

- CCG to ICS transition
- Single tender waivers

Tower Hamlets, Newham and Waltham Forest Area Committee

The TNW Area Committee was established in order to enable the CCG to take decisions on the delegated functions within the Integrated Care Partnership structure, as permitted by law, and to enable, where necessary, commissioner only decision-making on the Reserved Functions in a simple and efficient way. The delegated and reserved functions are set out in the CCG's Scheme of Reservation and Delegation (SoRD).

The duties of the Committee are to:

- Support the CCG in discharging its statutory financial duties, including through managing the budget delegated to it by the NEL CCG Governing Body.
- Provide assurance to the NEL CCG Governing Body.
- Have lead responsibility for the CCG's commissioning strategy in the ICP area.
- Have lead responsibility for population health management, supporting the CCG to discharge its statutory duties, including those relating to equality and inequality.
- Monitor performance in relation to quality and the improvement of services.
- Support stakeholder engagement and public involvement and consultation.

Committee effectiveness review

Comments were received from members on what they felt had gone well this quarter and what could be improved.

Things that went well:

- Committee members felt there was good engagement from members.

Areas for improvement:

- Members felt there was scope to improve quality of papers for decision making and a clearer read across for items needing endorsement or ratification

The membership and attendance record of the TNW Area Committee is outlined in the table below:

| Name of Committee member | 7 April 2022 | 19 May 2022 | 9 Jun 2022 | 22 Jun 2022 | Total attended/ total possible |
|--------------------------|--------------|-------------|------------|-------------|-----------------------------------|
| Fiona Smith (Chair) | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Muhammed Navqi | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Sam Everington | ✓ | ✓ | X | X | 2/4 |
| Ken Aswani | ✓ | X | X | X | 1/4 |
| Siobhan Harper | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Sunil Thakker | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Henry Black | X | X | X | X | 0/4 |

The AO was a member of the committee, however given the demands of transitioning to an ICB and establishing transitional ICB governance in preparation, deputising arrangements were put in place via CFO attendance.

The Area Committee is held in common with the TNW Delivery Group. The Delivery Group focused on operational healthcare issues within the areas of Tower Hamlets, Newham and Waltham Forest.

Other attendees with responsibilities within TNW such as finance, project management, commissioning services, quality and safety, planned and unplanned care and primary care were invited to meetings to respond directly to the committee about particular issues of concern and avoid delay in seeking further information.

The meeting was also attended regularly by:

- Anna Carratt, Director of Strategy and Planning, NEL CCG
- Kelvin Hankins, Director of Unplanned Care, NEL CCG
- Paul Calaminus, Chief Executive Officer, East London Foundation Trust
- Mark Lobban, Director of Integrated Care, London Borough of Waltham Forest and NEL CCG
- Warwick Tomsett, Director of Integrated Care, London Borough of Tower Hamlets and NEL CCG
- John Rooke, Director of Integrated Care, NEL CCG

- Chetan Vyas, Director of Quality and Safety, NEL CCG

The following key topics were discussed by the Committee between April and June 2022:

- TNW area budgets and financial management
- Single tender waivers
- Integrated care strategies
- Business cases relating to the TNW footprint
- Operational updates
- Whipps Cross Hospital redevelopment

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate the CCG's compliance with the principles set out in the Code (insofar as this applies to CCGs).

For the period of 1 April – 30 June 2022, and up to the date of signing this statement, we complied with the provisions set out in the Code, and applied the principles of the Code.

The CCG has discharged its duties as required under the NHS Primary Care Delegation arrangements.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations.

As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake the CCG's statutory duties.

Risk management arrangements and effectiveness

The CCG recognised that the establishment of effective risk management systems is fundamental to ensuring effective governance. The CCG had a risk management assurance

framework in place, the aim of which was to continually improve the quality of health service commissioning through the identification, prevention, control and containment of risks of all kinds. It is based on good practice and Department of Health (DH) guidance. The framework supports the assessment and management of risk throughout the organisation through a defined structure and clear systems and processes. It applied to all members, office holders and employees, permanent or temporary, of the CCG.

Capacity to Handle Risk

The Accountable Officer provides leadership to the risk management process and, as a member of the GB, ensures that the CCG's approach to risk management is transparent and the organisational structure supports effective systems and processes. The management of risk across each team or function is led and reported by the relevant director/senior responsible officer (SRO) with support from the corporate services team. Directors/SROs are involved in regular reviews of the risk register and the assurance framework. The Director of Corporate Affairs presents the GBAF to each GB meeting. Training is key to encouraging a culture where risk management is seen by the GB members and our staff as essential. Presentations on counter fraud have been given to GB members and at the all-staff briefing, and the counter fraud officer holds monthly drop-in sessions for staff to talk about any issues.

Risks are explicitly discussed and mitigation reviewed at the following meetings:

- Senior management team meetings for identification and recording of ICP risks
- Finance and performance committee
- Quality, safety and improvement committee
- Primary care commissioning committee
- Audit and risk committee
- ICP area committees
- Governing Body

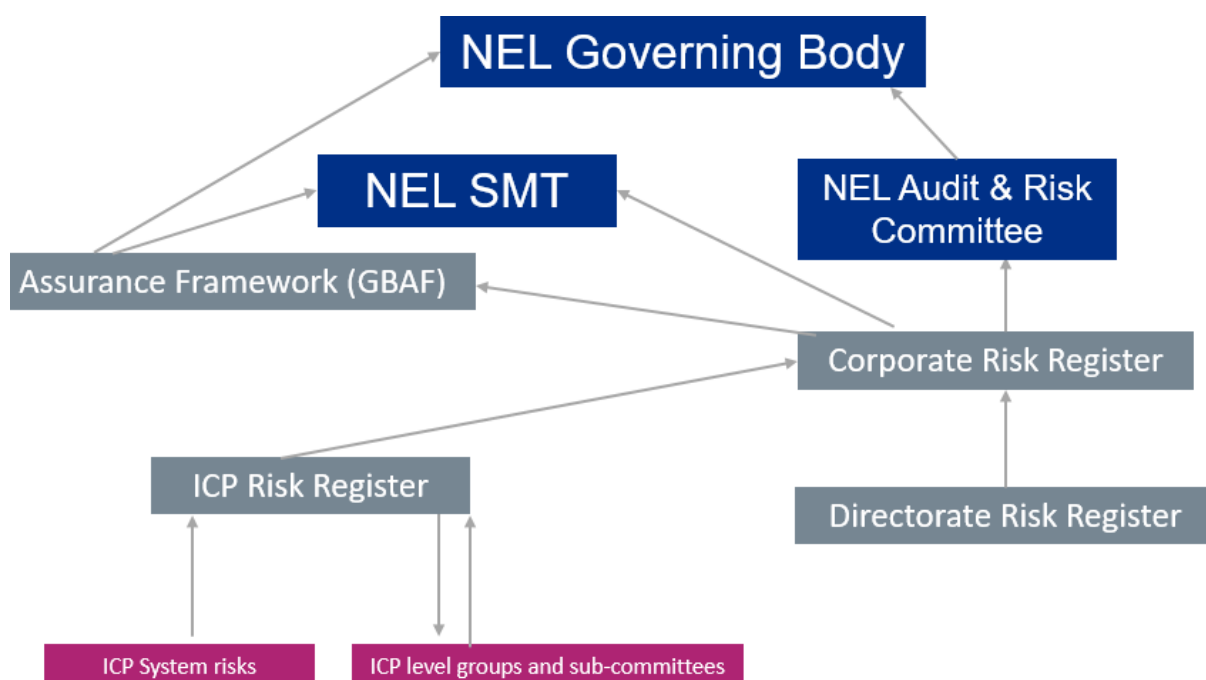
The process in place ensures that there are regular forums to collaboratively review the common risks, raise new risks, discuss and constructively challenge the effectiveness of the mitigating actions and suggest changes as appropriate. The risk registers for the CCG were reviewed and where still live, compiled and included in the legacy risk registers provided for each of the new chief officers of the ICB.

Risk Assessment

The key risks for the CCG during April – June 2022 relate to the CCG’s response and support to the Covid-19 pandemic and the achievement of our constitutional targets, as well as wider performance and financial risks. The CCG monitors risks closely, as described within the governance statement in this report. The risks on the GBAF for the past year were the following:

- Performance against the 2022/23 Operating Plan metrics, specifically in relation to elective recovery.
- Ensuring financial resources are deployed effectively and fulfilling the CCG’s statutory financial duties.
- Continuing Healthcare; including discharge to assess pathways, digital systems and Liberty Protection Safeguards.
- Supporting the vaccination programme.
- Health inequalities.

The risk management structure of the CCGs is shown below:



The risk management structure shows the links between the operational level risks at team level, and the strategic risks which are managed at senior organisational or CCG GB level.

Risks are identified in various ways:

- Proactive risk assessments
- Incident reports (including serious incidents and never events)
- Complaints

- Audits
- Serious case reviews
- Feedback from Healthwatch, the patient engagement groups and Health Scrutiny Committees
- Service improvement programmes
- General stakeholder feedback

Risk management is embedded in the organisation in a number of ways. The GBAF is presented to every GB meeting near the beginning of the agenda to provide context for later items related to finance, quality, performance, commissioning and strategy.

Declarations of conflicts of interest features at the start of each GB meeting and the register of interests is included at the start of the agenda and within the pack. The register of interests is reviewed periodically by the lay member for governance and a smaller working group of governance and legal officers.

All reports to the GB, Audit and Risk Committee and other committees require a cover sheet which asks document authors to consider the following:

- Risk implications
- Impact on equality
- Resource/investment requirements
- How this will affect local people and health inequalities

The risk management policy and strategy were available on the staff intranet, together with the CCG's policies in relation to standards of business conduct, conflicts of interest, gifts and hospitality, freedom to speak up and fraud prevention.

Risks were discussed with directors and their teams bi-monthly and at the CCG's senior management meeting.

Based on criteria set out in the risk management policy and the current risk rating, significant risks are escalated from the corporate risk register to the GBAF. Some of the risks that are rated as severe (red rated) are escalated to the GBAF where that risk is deemed to pose a significant threat to the achievement of the CCG's corporate objectives. When rating risks, other factors are also taken into consideration, such as whether they are common to a number of departments/functions or where additional controls have not succeeded in reducing the risk grading.

The risk management scoring system is used systematically in each review of the risk register. This ensures that risks are escalated appropriately to the GBAF. Risks escalated to the GBAF

are reviewed with the relevant director prior to GB meetings. There is also a yearly audit of our GBAF and risk management processes undertaken by the CCG's internal auditors which checks our adherence to policy and best practice.

The Audit and Risk Committee periodically reviews the management process that is in place for the management of risks and receives reports on specific emerging risks and risk mitigation.

The organisation's 'risk appetite' is captured for each risk on the GBAF.

As mentioned earlier, the legacy CCG risk registers have been transferred to the ICB chief officers to ensure continuity. The CCG's internal auditors worked with the governance team and departmental leads in designing the new risk management process for the ICB, which was included in the new ICB Governance Handbook for approval at the inaugural board meeting 1 July.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

Our internal auditors RSM have completed this audit for the most recent year (2021/22) and gave a rating of substantial assurance. The new policy for managing conflicts of interest, building on the good practice and experience within the CCG, was included in the ICB's Governance Handbook.

Data Quality

The CCG received activity and financial data from London Shared Services (LSS) as part of a contract for a range of services from that organisation. The quality of the data used by the governing body is considered to be acceptable.

Additional scrutiny and validation of data was established by NHS England and Public Health England through the pandemic including on vaccine uptake, Covid-19 case rates and hospital discharge - all of which was subject to high degrees of local, regional and national scrutiny.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing/have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

Business Critical Models

An appropriate framework and environment are in place to provide quality assurance of business critical models via LSS, in line with the recommendations in the Macpherson report. No business critical models have been identified that require information about quality assurance processes for those models to be provided to the Analytical Oversight Committee chaired by the Chief Analyst in the Department of Health and Social Care.

Third party assurances

The CCG commissions LSS to run elements of our commissioning function – such as contracting, business intelligence, media relations and payroll. The service standards are monitored as part of a service level agreement and the Audit and Risk Committee receives regular auditor reports on contracted-for services.

Control Issues

There were no control issues identified via the most recent Governance Statement return, and this remains the position at the time of completing this quarter one report.

Review of economy, efficiency and effectiveness of the use of resources

The CCG had a comprehensive governance and reporting framework in place to monitor use of resources, identify any issues and ensure the appropriate measures were taken to address any variance from plans. The governing body/joint committee received regular summary reports concerning the CCG's financial performance, and the finance committee had authority to conduct more detailed scrutiny and report back.

The Finance and Performance Committee convened regularly to scrutinise the detailed operational financial performance of the CCG.

The Audit and Risk Committee was chaired by the GB Lay Member for Governance with additional lay membership. The Committee performs the role of oversight and scrutiny of CCG policies, procedures and systems of internal control, and had a focus on ensuring that conflicts of interest are managed in line with the CCG's Constitution.

Underpinning the CCG's governance framework were the prime financial policies, which set out the key business rules that govern the organisation, including internal control, audit, standards of business conduct and budgetary control. They also incorporated the scheme of delegation. This set out the level of authority to act and make decisions, which have been delegated from the CCG GB to the various executive committees, in addition to the authorisation limits set by the GB for the management posts within the organisation to authorise expenditure.

Much of the CCG's commissioning spend was covered by contracts managed on our behalf by the LSS. The CCG received assurances on LSS performance through regular contractual meetings and, key performance indicator monitoring.

Delegation of functions

LSS also managed contracts with key providers on behalf of the CCG. The process is overseen by the CCG and regularly reviewed through the internal audit process and discussion at the Audit and Risk Committee. In addition, the Chief Finance Officer, finance directors and relevant other directors met with the LSS lead staff regularly to discuss performance and agree actions where there were concerns. Generally, the process has worked well over the reporting period. The CCG was a delegated commissioner of primary care (from NHS England). The CCG's arrangements for managing this function were subject to regular review by internal audit and the Audit and Risk Committee.

Counter fraud arrangements

An Accredited Counter Fraud Specialist, RSM UK, is contracted to undertake counter fraud work proportionate to identified risks.

- The CCG Audit and Risk Committee received a report against each of the 'Standards for Commissioners' at least annually. There was executive support and direction for a proportionate proactive work plan to address identified risks.
- Regular reports were presented to the CCG's Audit and Risk Committee with progress against the work plan, updates on cases and policy updates.
- A member of the governing body was proactively and demonstrably responsible for tackling fraud, bribery and corruption.

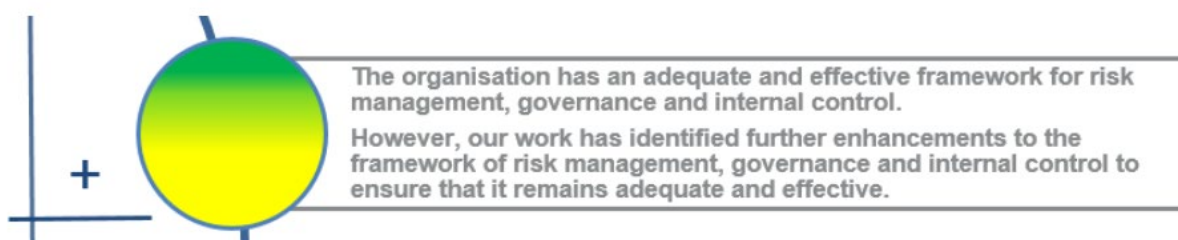
Appropriate action was taken regarding any NHS Protect quality assurance recommendations.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

For the period between 1st April 2022 and 30 June 2022, our draft head of internal audit opinion for North East London Clinical Commissioning Group is as follows:

Draft Head of internal audit opinion 2022 -



The opinion takes into consideration the framework in place in the period up to and including 30 June 2022; and our cumulative knowledge of the North East London Clinical Commissioning Group (CCG). The opinion does not consider the arrangements of the Integrated Care Board (ICB) or the Integrated Care Partnership (ICP).

During 1 April –30 June this year, Internal Audit issued the following audit reports:

| Area of Audit | Level of Assurance Given |
|---------------|--------------------------|
|---------------|--------------------------|

| | |
|---|-----------------------|
| Discovery – Patient Information Database | Partial Assurance |
| Due Diligence and Risk Management – Phase two | Substantial Assurance |
| Estates Management | Reasonable Assurance |

The findings of the audits above were discussed at the ICB’s inaugural Audit and Risk Committee meeting to ensure the learning and related actions/follow up is transferred to the ICB.

Review of the effectiveness of governance, risk management and internal control

As Acting Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the CCG. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

No significant internal control issues have been identified.

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

Please refer to page 35 which includes the membership of the CCG's Remuneration Committee.

Policy on the remuneration of senior managers

The NHS has adopted the recommendations outlined in the Greenbury report in respect of the disclosure of senior managers' remuneration and the manner in which it is determined. Senior managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the CCG. This means those who influence the decisions of the CCG as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members. This report outlines how those recommendations have been implemented by the CCG.

The remuneration of senior managers is determined by the Remuneration and Workforce Committee in line with national NHS 'Agenda for Change' and very senior manager pay guidance. The Committee reviews information about director and GB members' responsibilities, as well as comparing remuneration in similar organisations to set pay.

Remuneration of Very Senior Managers

During April to June, one senior manager's combined salary was more than £150,000 per annum (the salary of the prime minister). The pay was determined by NHS England and discussed through the CCG's remuneration committee in line with national guidance. Salary levels are benchmarked and in line with equivalent roles.

Senior manager remuneration

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the

benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Note: CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement of for loss of office

No compensation on early retirement for loss of office was made during the financial year.

Payments to past directors

No payments were made to past directors during the financial year.

Pay ratio information

Percentage change in remuneration of highest paid director

| | Salary and allowances |
|--|------------------------------|
| The percentage change from the previous financial year in respect of the highest paid director | 0% |
| The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole | 5% |

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in NHS North East London CCG in the reporting period 1 April 2022 to 30 June 2022 was £245k to £250k (2021-22 £245k to £250k).

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

| 2022/23 | 25 th percentile | Median pay ratio | 75 th percentile pay ratio |
|--|-----------------------------|------------------|---------------------------------------|
| Total remuneration (£) | 39,733 | 54,223 | 72,761 |
| Salary component of total remuneration (£) | 39,733 | 54,223 | 72,761 |
| Pay ratio information | 6.38 | 4.56 | 3.49 |
| 2021/22 | | | |
| Total remuneration (£) | 38,767 | 54,223 | 70,959 |
| Salary component of total remuneration (£) | 38,767 | 54,223 | 70,959 |
| Pay ratio information | 6.38 | 4.56 | 3.49 |

During the reporting period 2022/23, 0 employees received remuneration in excess of the highest-paid director/member (2021/22: 0).

Remuneration ranged from £0 to £5k and £245k to £250k (2021-22 £0 to £5k and £245k to £250k).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Senior manager remuneration (including salary and pension entitlements) – subject to audit

| Name and Title | Q1 2022/23 | | | | | |
|--|--------------------------|--|---|--|--|-------------------------|
| | Salary (bands of £5,000) | Expense Payments (taxable) to nearest £100 | Performance pay and bonuses (bands of £5,000) | Long term performance pay and bonuses (bands of £5000) | All Pension related benefits (bands of £2,500) * | Total (bands of £5,000) |
| | £000s | £s | £000s | £000s | £000s | £000s |
| Clinical Directors | | | | | | |
| Dr Jagan John CCG Chair and Clinical Chair Barking & Dagenham 01/04/2022 - 30/06/2022 | 20 - 25 | 0 | 0 | 0 | n/a | 20 - 25 |
| Prof Sir Sam Everington Deputy Clinical CCG Chair and Clinical Chair Tower Hamlets 01/04/2022 - 30/06/2022 | 20 - 25 | 0 | 0 | 0 | n/a | 20 - 25 |
| Dr Mark Rickets Clinical Chair City & Hackney 01/04/2022 - 30/06/2022 | 15 - 20 | 0 | 0 | 0 | n/a | 15 - 20 |
| Dr Atul Aggarwal Clinical Chair Havering 01/04/2022 - 30/06/2022 | 20 - 25 | 0 | 0 | 0 | n/a | 20 - 25 |
| Dr Muhammad Waqqas Naqvi Clinical Chair Newham 01/04/2022 - 30/06/2022 | 20 - 25 | 0 | 0 | 0 | n/a | 20 - 25 |
| Dr Anil Mehta Clinical Chair Redbridge 01/04/2022 - 30/06/2022 | 20 - 25 | 0 | 0 | 0 | n/a | 20 - 25 |
| Dr Ken Aswani Clinical Chair Waltham Forest 01/04/2022 - 30/06/2022 | 20 - 25 | 0 | 0 | 0 | n/a | 20 - 25 |
| Lay Members and Independent Clinicians | | | | | | |
| Sue Evans Deputy CCG Chair and Lay Member Primary Care 01/04/2022 - 30/06/2022 | 5 - 10 | 0 | 0 | 0 | n/a | 5 - 10 |
| Kash Pandya Lay Member Governance 01/04/2022 - 30/06/2022 | 5 - 10 | 0 | 0 | 0 | n/a | 5 - 10 |
| Noah Curthoys Lay Member Performance 01/04/2022 - 30/06/2022 | 5 - 10 | 0 | 0 | 0 | n/a | 5 - 10 |
| Khalil Ali Lay Member Patient and Public Performance 01/04/2022 - 30/06/2022 | 10 - 15 | 0 | 0 | 0 | n/a | 10 - 15 |
| Fiona Smith Independent Clinical Member - Registered Nurse 01/04/2022 - 30/06/2022 | 5 - 10 | 0 | 0 | 0 | n/a | 5 - 10 |
| Charlotte Harrison Independent Clinical Member - Secondary Care Clinician 01/04/2022 - 30/06/2022 | 0 - 5 | 0 | 0 | 0 | n/a | 0 - 5 |
| Executive Directors | | | | | | |
| Zina Etheridge Chief Executive Officer Designate 01/04/2022 - 30/06/2022 | 60 - 65 | 0 | 0 | 0 | 12.5 - 15 | 75 - 80 |
| Henry Black CFO Designate 01/04/2022 - 30/06/2022 | 35 - 40 | 0 | 0 | 0 | 5 - 7.5 | 45 - 50 |
| Steve Collins Executive Director of Finance 01/04/2022 - 30/06/2022 | 35 - 40 | 0 | 0 | 0 | 7.5 - 10 | 45 - 50 |
| Diane Jones NEL ICS Chief Nurse 01/04/2022 - 30/06/2022 | 35 - 40 | 0 | 0 | 0 | 20 - 22.5 | 55 - 60 |
| Ceri Jacob # Managing Director - BHR 01/04/2022 - 30/06/2022 | 35 - 40 | 0 | 0 | 0 | n/a | 35 - 40 |
| Archna Mathur Director of Performance & Assurance 01/04/2022 - 30/06/2022 | 30 - 35 | 0 | 0 | 0 | 7.5 - 10 | 40 - 45 |
| Marie Price Director of Corporate Affairs 01/04/2022 - 30/06/2022 | 25 - 30 | 0 | 0 | 0 | 5 - 7.5 | 30 - 35 |
| Rachel Patterson Director of HR and People 01/04/2022 - 30/06/2022 | 30 - 35 | 0 | 0 | 0 | 0 - 2.5 | 30 - 35 |

| | | | | | | |
|---|---------|---|---|---|-----------|---------|
| Simon Hall Director of Transformation 01/04/2022 - 30/06/2022 | 30 - 35 | 0 | 0 | 0 | 7.5 - 10 | 40 - 45 |
| Siobhan Harper Director of CCG Transition 01/04/2022 - 30/06/2022 | 30 - 35 | 0 | 0 | 0 | 15 - 17.5 | 45 - 50 |
| Christopher Cotton Director of ICP Transition 01/04/2022 - 30/06/2022 | 30 - 35 | 0 | 0 | 0 | 7.5 - 10 | 40 - 45 |
| Marie Gabriel ICB Chair Designate 01/04/2022 - 30/06/2022 | 15 - 20 | 0 | 0 | 0 | n/a | 15 - 20 |
| Francesca Okosi Chief People and Culture Officer 13/06/2022 - 30/06/2022 | 5 - 10 | 0 | 0 | 0 | 0 - 2.5 | 5 - 10 |
| Charlotte Pomey Chief Participation and Place Officer 27/06/2022 - 30/06/2022 | 0 - 5 | 0 | 0 | 0 | 0 - 2.5 | 0 - 5 |

Directors who have chosen not to be covered by the pension arrangements during the reporting year

* Pension Related Benefits have been calculated using information provided by the Pensions Agency for pension entitlements as at 31st March 2023; these reflect a proportion of the full increase for the year ended 31 March 2023.

| Name and Title | 2021/22 | | | | | |
|--|--------------------------|--|---|--|--|-------------------------|
| | Salary (bands of £5,000) | Expense Payments (taxable) to nearest £100 | Performance pay and bonuses (bands of £5,000) | Long term performance pay and bonuses (bands of £5000) | All Pension related benefits (bands of £2,500) | Total (bands of £5,000) |
| | £000s | £s | £000s | £000s | £000s | £000s |
| Clinical Directors | | | | | | |
| Dr Jagan John CCG Chair and Clinical Chair Barking & Dagenham 01/04/2021 - 31/03/2022 | 85 - 90 | 0 | 0 | 0 | n/a | 85 - 90 |
| Prof Sir Sam Everington Deputy Clinical CCG Chair and Clinical Chair Tower Hamlets 01/04/2021 - 31/03/2022 | 85 - 90 | 0 | 0 | 0 | n/a | 85 - 90 |
| Dr Mark Ricketts Clinical Chair City & Hackney 01/04/2021 - 31/03/2022 | 85 - 90 | 0 | 0 | 0 | n/a | 85 - 90 |
| Dr Atul Aggarwal Clinical Chair Havering 01/04/2021 - 31/03/2022 | 85 - 90 | 0 | 0 | 0 | n/a | 85 - 90 |
| Dr Muhammad Waqqas Naqvi Clinical Chair Newham 01/04/2021 - 31/03/2022 | 85 - 90 | 0 | 0 | 0 | n/a | 85 - 90 |
| Dr Anil Mehta Clinical Chair Redbridge 01/04/2021 - 31/03/2022 | 85 - 90 | 0 | 0 | 0 | n/a | 85 - 90 |
| Dr Ken Aswani Clinical Chair Waltham Forest 01/04/2021 - 31/03/2022 | 85 - 90 | 0 | 0 | 0 | n/a | 85 - 90 |
| Lay Members and Independent Clinicians | | | | | | |
| Sue Evans Deputy CCG Chair and Lay Member Primary Care 01/04/2021 - 31/03/2022 | 35 - 40 | 0 | 0 | 0 | n/a | 35 - 40 |
| Kash Pandya Lay Member Governance 01/04/2021 - 31/03/2022 | 40 - 45 | 0 | 0 | 0 | n/a | 40 - 45 |
| Noah Curthoys Lay Member Performance 01/04/2021 - 31/03/2022 | 35 - 40 | 0 | 0 | 0 | n/a | 35 - 40 |
| Khalil Ali Lay Member Patient and Public Performance 01/04/2021 - 31/03/2022 | 40 - 45 | 0 | 0 | 0 | n/a | 40 - 45 |
| Fiona Smith Independent Clinical Member - Registered Nurse 01/04/2021 - 31/03/2022 | 45 - 50 | 0 | 0 | 0 | n/a | 45 - 50 |
| Charlotte Harrison Independent Clinical Member - Secondary Care Clinician 01/04/2021 - 31/03/2022 | 15 - 20 | 0 | 0 | 0 | n/a | 15 - 20 |

| Executive Directors | | | | | | |
|---|-----------|---|---|---|-----------|-----------|
| Zina Etheridge Chief Executive Officer Designate of the Integrated Care Board for North East London 22/02/2022 - 31/03/2022 | 25 - 30 | 0 | 0 | 0 | 5 - 7.5 | 30 - 35 |
| Henry Black Acting Accountable Officer 01/04/2021 - 31/03/2022 | 155 - 160 | 0 | 0 | 0 | 82.5 - 85 | 235 - 240 |
| Steve Collins Acting Chief Finance Officer 01/04/2021 - 31/03/2022 | 140 - 145 | 0 | 0 | 0 | 35 - 37.5 | 175 - 180 |
| Diane Jones NEL ICS Chief Nurse 01/07/2021 - 31/03/2022 | 95 - 100 | 0 | 0 | 0 | 65 - 67.5 | 165 - 170 |
| Ceri Jacob # Managing Director - BHR 01/04/2021 - 31/03/2022 | 140 - 145 | 0 | 0 | 0 | n/a | 140 - 145 |
| Selina Douglas # Managing Director - TNW 01/04/2021 - 31/10/2021 | 75 - 80 | 0 | 0 | 0 | n/a | 75 - 80 |
| Archna Mathur Director of Performance & Assurance 01/04/2021 - 31/03/2022 | 130 - 135 | 0 | 0 | 0 | 55 - 57.5 | 185 - 190 |

| | | | | | | |
|--|-----------|---|---|---|-----------|-----------|
| Marie Price Director of Corporate Affairs 01/04/2021 - 31/03/2022 | 130 - 135 | 0 | 0 | 0 | 50 - 52.5 | 180 - 185 |
| Rachel Patterson Director of HR and People 01/04/2021 - 31/03/2022 | 130 - 135 | 0 | 0 | 0 | 92.5 - 95 | 220 - 225 |
| Simon Hall Director of Transformation 01/04/2021 - 31/03/2022 | 130 - 135 | 0 | 0 | 0 | 32.5 - 35 | 160 - 165 |
| Siobhan Harper Director of CCG Transition 19/10/2021 - 31/03/2022 | 55 - 60 | 0 | 0 | 0 | 65 - 67.5 | 125 - 130 |

Pension benefits of senior managers as at 30 June 2022 - subject to audit

The following schedule discloses further information regarding pension entitlements

| Name & Title | Real increase in pension at pension age (bands of £2,500) | Real increase in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 30th June 2022 (bands of £5,000) | Lump sum at pension age related to accrued pension at 30th June 2022 (bands of £5,000) | Cash Equivalent Transfer Value at 1st April 2022 | Real Increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 30th June 2022 | Employer's contribution to stakeholder pension |
|--------------------|---|--|--|--|--|---|--|--|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Zina Etheridge | 0 - 2.5 | 0 | 0 - 5 | 0 | 6 | 6 | 21 | 0 |
| Henry Black | 0 - 2.5 | 0 - 2.5 | 40 - 45 | 65 - 70 | 606 | 4 | 621 | 0 |
| Steve Collins | 0 - 2.5 | 0 | 10 - 15 | 0 | 123 | 4 | 134 | 0 |
| Diane Jones | 0 - 2.5 | 0 - 2.5 | 35 - 40 | 60 - 65 | 635 | 18 | 663 | 0 |
| Archna Mathur | 0 - 2.5 | 0 | 35 - 40 | 65 - 70 | 576 | 6 | 592 | 0 |
| Marie Price | 0 - 2.5 | 0 | 25 - 30 | 0 | 337 | 5 | 349 | 0 |
| Rachel Patterson | 0 - 2.5 | 0 | 45 - 50 | 95 - 100 | 860 | 3 | 874 | 0 |
| Simon Hall | 0 - 2.5 | 0 | 60 - 65 | 130 - 135 | 1,210 | 12 | 1,236 | 0 |
| Siobhan Harper | 0 - 2.5 | 0 - 2.5 | 45 - 50 | 90 - 95 | 832 | 16 | 859 | 0 |
| Christopher Cotton | 0 - 2.5 | 0 | 5 - 10 | 0 | 46 | 1 | 53 | 0 |
| Francesca Okosi | 0 - 2.5 | 0 | 15 - 20 | 0 | 226 | 1 | 229 | 0 |
| Charlotte Pomery | 0 - 2.5 | 0 | 0 - 5 | 0 | 0 | 0 | 0 | 0 |

The ICB was only able to obtain information for pension entitlements for the period ending 31 March 2023. As a result estimated values for pension, lump sum and CETV as at 30 June 2022 have been calculated incorporating a proportion of the increase during 2022-23; these are considered to be reasonable approximations for the values reported for 30 June 2022. The real increases in pension and lump sum have been calculated as a proportion of the full increase for the year ended 31 March 2023.

Note: CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures.

2021-22

| Name & Title | Real increase in pension at pension age (bands of £2,500) | Real increase in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31st March 2022 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31st March 2022 (bands of £5,000) | Cash Equivalent Transfer Value at 1st April 2021 | Real Increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31st March 2022 | Employer's contribution to stakeholder pension |
|------------------|---|--|---|---|--|---|---|--|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Zina Etheridge | 0 - 2.5 | 0 | 0 - 5 | 0 | 0 | 0 | 6 | 0 |
| Henry Black | 2.5 - 5 | 5 - 7.5 | 35 - 40 | 65 - 70 | 521 | 60 | 606 | 0 |
| Steve Collins | 2.5 - 5 | 0 | 5 - 10 | 0 | 86 | 16 | 123 | 0 |
| Diane Jones | 2.5 - 5 | 2.5 - 5 | 35 - 40 | 60 - 65 | 559 | 40 | 635 | 0 |
| Archana Mathur | 2.5 - 5 | 2.5 - 5 | 35 - 40 | 65 - 70 | 511 | 44 | 576 | 0 |
| Marie Price | 2.5 - 5 | 0 | 25 - 30 | 0 | 286 | 31 | 337 | 0 |
| Rachel Patterson | 5 - 7.5 | 7.5 - 10 | 45 - 50 | 95 - 100 | 751 | 86 | 860 | 0 |
| Simon Hall | 2.5 - 5 | 0 - 2.5 | 60 - 65 | 130 - 135 | 1,142 | 43 | 1,210 | 0 |
| Siobhan Harper | 2.5 - 5 | 5 - 7.5 | 40 - 45 | 90 - 95 | 672 | 62 | 832 | 0 |

Staff Report

Number of senior managers

| Senior Manager | Head Count |
|------------------------|------------|
| Band 9 + Clinical Lead | 98 |
| Consultant Lead | 1 |
| VSM | 15 |
| Total | 114 |

Staff numbers and costs

| | Admin | | | Programme | | | Total | | | 2022-23 |
|--|---------------------|------------|--------------|---------------------|--------------|---------------|---------------------|--------------|---------------|---------|
| | Permanent Employees | Other | Total | Permanent Employees | Other | Total | Permanent Employees | Other | Total | £'000 |
| Employee Benefits | | | | | | | | | | |
| Salaries and wages | 3,846 | 623 | 4,469 | 5,725 | 3,212 | 8,937 | 9,571 | 3,835 | 13,406 | |
| Social security costs | 473 | 2 | 474 | 733 | 35 | 768 | 1,206 | 37 | 1,243 | |
| Employer contributions to the NHS Pension Scheme | 922 | 2 | 924 | 721 | 40 | 761 | 1,643 | 42 | 1,685 | |
| Other pension costs | - | - | - | 3 | - | 3 | 3 | - | 3 | |
| Apprenticeship Levy | - | - | - | 49 | - | 49 | 49 | - | 49 | |
| Total employee benefits expenditure | 5,241 | 627 | 5,868 | 7,231 | 3,287 | 10,518 | 12,472 | 3,914 | 16,386 | |

| | Admin | | | Programme | | | Total | | | 2021-22 |
|--|---------------------|--------------|---------------|---------------------|--------------|---------------|---------------------|---------------|---------------|---------|
| | Permanent Employees | Other | Total | Permanent Employees | Other | Total | Permanent Employees | Other | Total | £'000 |
| Employee Benefits | | | | | | | | | | |
| Salaries and wages | 15,542 | 2,636 | 18,178 | 18,569 | 9,855 | 28,424 | 34,111 | 12,491 | 46,602 | |
| Social security costs | 1,832 | 3 | 1,835 | 2,185 | 8 | 2,193 | 4,017 | 11 | 4,028 | |
| Employer contributions to the NHS Pension Scheme | 3,571 | 4 | 3,575 | 2,236 | 9 | 2,245 | 5,807 | 13 | 5,820 | |
| Other pension costs | - | - | 0 | 18 | - | 18 | 18 | - | 18 | |
| Apprenticeship Levy | 105 | - | 105 | - | - | - | 105 | - | 105 | |
| Total employee benefits expenditure | 21,050 | 2,643 | 23,693 | 23,008 | 9,872 | 32,880 | 44,058 | 12,515 | 56,573 | |

Staff composition

Employee group

| NEL CCG | Female | Male | Total |
|---|---------------|-------------|--------------|
| NEL CCG Employees | 534 | 367 | 901 |
| NEL CCG office holders - (engaged to provide specific roles but not engaged on contracts of employment e.g. clinical leads, lay members, etc) | 41 | 31 | 72 |
| Total | 575 | 398 | 973 |

Gender

| Gender | Head Count |
|---------------|-------------------|
| Female | 575 |
| Male | 398 |
| Total | 973 |

Declared disability

| Disability | Headcount |
|----------------------|------------------|
| No | 799 |
| Not Declared | 75 |
| Prefer Not To Answer | 23 |
| Unspecified | 24 |
| Yes | 52 |
| Total | 973 |

Ethnicity

| Ethnic origin | Head Count |
|----------------------|-------------------|
| A White – British | 342 |

| Ethnic origin | Head Count |
|--------------------------------------|-------------------|
| B White – Irish | 20 |
| C White - Any other White background | 37 |
| C2 White Northern Irish | 2 |
| C3 White Unspecified | 1 |
| CA White English | 14 |
| CB White Scottish | 3 |
| CC White Welsh | 1 |
| CF White Greek | 1 |
| CK White Italian | 2 |
| CN White Gypsy/Romany | 1 |
| CP White Polish | 1 |
| CX White Mixed | 1 |
| CY White Other European | 8 |
| D Mixed - White & Black Caribbean | 12 |
| E Mixed - White & Black African | 5 |
| F Mixed - White & Asian | 4 |
| G Mixed - Any other mixed background | 10 |
| GA Mixed - Black & Asian | 2 |
| GC Mixed - Black & White | 2 |
| GD Mixed - Chinese & White | 1 |
| GF Mixed - Other/Unspecified | 5 |
| H Asian or Asian British – Indian | 86 |
| J Asian or Asian British – Pakistani | 25 |

| Ethnic origin | Head Count |
|---|-------------------|
| K Asian or Asian British – Bangladeshi | 69 |
| L Asian or Asian British - Any other Asian background | 13 |
| LB Asian Punjabi | 8 |
| LC Asian Kashmiri | 1 |
| LD Asian East African | 3 |
| LF Asian Tamil | 2 |
| LH Asian British | 3 |
| LK Asian Unspecified | 3 |
| M Black or Black British – Caribbean | 40 |
| N Black or Black British – African | 87 |
| P Black or Black British - Any other Black background | 5 |
| PC Black Nigerian | 6 |
| PD Black British | 27 |
| PE Black Unspecified | 1 |
| R Chinese | 11 |
| S Any Other Ethnic Group | 6 |
| SA Vietnamese | 1 |
| SC Filipino | 3 |
| SD Malaysian | 1 |
| SE Other Specified | 5 |
| Unspecified | 12 |
| Z Not Stated | 80 |
| Total | 973 |

Religion

| Religious Belief | Head Count |
|--|------------|
| Atheism | 132 |
| Buddhism | 6 |
| Christianity | 331 |
| Hinduism | 51 |
| I do not wish to disclose my religion/belief | 212 |
| Islam | 118 |
| Jainism | 3 |
| Judaism | 9 |
| Other | 62 |
| Sikhism | 28 |
| Unspecified | 21 |
| Total | 973 |

Age

| Age Range | Head Count |
|--------------|------------|
| <=20 Years | 1 |
| >=71 Years | 3 |
| 21-25 | 28 |
| 26-30 | 71 |
| 31-35 | 133 |
| 36-40 | 168 |
| 41-45 | 156 |
| 46-50 | 123 |
| 51-55 | 128 |
| 56-60 | 101 |
| 61-65 | 53 |
| 66-70 | 8 |
| Total | 973 |

Sexual orientation

| Sexual Orientation | Head Count |
|--|------------|
| Bisexual | 13 |
| Gay or Lesbian | 35 |
| Heterosexual or Straight | 758 |
| Not stated (person asked but declined to provide a response) | 143 |
| Other sexual orientation not listed | 1 |
| Undecided | 2 |
| Unspecified | 21 |
| Total | 973 |

Sickness absence data

| | Average FTE for 2022 | Average Annual Sick Days per FTE | Sum of FTE Days Sick | Sum of FTE Days Available |
|---------------------------|----------------------|----------------------------------|----------------------|---------------------------|
| NHS North East London CCG | 596 | 4.2 | 1,363 | 72,546 |

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the Period covered: January to December 2022

NHS Digital Statistics

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Staff turnover percentages

| | 2022 / 04 | 2022 / 05 | 2022 / 06 | 2022 / 07 |
|---------------------------|-----------|-----------|-----------|-----------|
| Turnover Rate (Headcount) | 1.26% | 1.26% | 1.83% | 1.14% |

Staff policies and support

The CCG continued to develop a range of support and development opportunities for staff. This included:

- **The launch of the second round of the Reverse Mentoring programme**

Reverse mentoring is when a worker in a senior position is mentored by someone in a more junior position than themselves. The programme provides a space for staff to explore areas of good practice and generate ideas and priorities for improving inclusive culture.

- **Staff awards**

For the first time since becoming a single organisation, staff celebrated the dedication and achievements of colleagues in our first staff awards. There were 190 nominations across ten categories. The awards were split into two sections, with seven categories based on the new organisational behaviours.

Staff wellbeing resources and support

- We established a 'one stop shop' staff wellbeing hub, bringing together the most important and impactful resources to enable and support the wellbeing of staff. In

addition, a working group was set up to explore how to support staff with the rising cost of living with a new range of supporting resources.

- KeepingWellNEL provides confidential, independent and inclusive wellbeing support, advice and resources to health and care staff across north east London. With a holistic approach the service supports wellbeing in ways that are most reflective of people’s needs, with wellbeing advisors available 8am-8pm Monday-Saturday [Keeping Well Nel](#).

Always learning

- Our corporate subscription to NHS Elect provides all staff with access to a range of interactive webinars, virtual workshops and learning resources, on a breadth of different and important core topics. With many staff making use of the service, popular topics include project management, report writing, interview skills and systems thinking.
- Coaching can be a powerful way of learning; giving people the space to understand a situation more clearly, assess their strengths and set developmental goals. Thought provoking, creative and empowering, we know that coaching is a valuable opportunity for all, particularly during changing and complex periods. Six members of staff have started coaching apprenticeships, which will see them not only develop their coaching practice but also support people in the organisation with 1-1 coaching as they train.

Trade Union Facility Time Reporting Requirements

| Number of employees who were relevant union officials during the relevant period | Full-time equivalent employee number |
|--|--|
| 2 | Two full time members of staff who are local Trade Union Officers devoting part of their time to TU activities |

| Percentage of time | Number of employees |
|--------------------|--|
| 0% | 2 (based on c 7.5 hours/week per rep: 1 rep = 20%, 1 rep = 5%) |
| 1-50% | |
| 51%-99% | |
| 100% | |

Other employee matters

NHS London Shared Service consulted its staff on a move to other NHS organisations in London. The 30-day consultation launched on 26 April for staff at NHS London Shared Service (formerly NEL CSU), who were consulted on their proposed assignment to four London CCGs and other receiving organisations in London. The consultation concluded on 26 May 2022. The mechanism of transfer for LSS staff to their receiver organisations was a combination of

Transfer Scheme, TUPE and COSOP (also known as TUPE-like), underpinned by the overarching principles of an employment commitment for all and protection of employment, which guided the consultation. Staff joined the new organisation in July, but were engaged as much as possible in advance of the transfer.

Expenditure on consultancy

| Total £'000 | 2022-23 | | 2021-22 |
|----------------|----------------|--------------------|----------------|
| | Admin £'000 | Programme £'000 | Total £'000 |
| 879 | 2 | 877 | 3,116 |

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 30 June 2022 for more than £245* per day:

| | Number |
|--|--------|
| Number of existing engagements as of 30 June 2022 | 63 |
| <i>Of which, the number that have existed:</i> | |
| for less than one year at the time of reporting | 21 |
| for between one and two years at the time of reporting | 42 |
| for between 2 and 3 years at the time of reporting | 0 |
| for between 3 and 4 years at the time of reporting | 0 |
| for 4 or more years at the time of reporting | 0 |

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The CCG confirms that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2022 and 30 June 2022 for more than £245⁽¹⁾ per day:

| | Number |
|--|---------------|
| No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022 | 63 |
| <i>Of which:</i> | |
| No. not subject to off-payroll legislation ⁽²⁾ | 0 |
| No. subject to off-payroll legislation and determined as in-scope of IR35 ⁽²⁾ | 62 |
| No. subject to off-payroll legislation and determined as out of scope of IR35 ⁽²⁾ | 1 |
| the number of engagements reassessed for compliance or assurance purposes during the year | 0 |
| Of which: no. of engagements that saw a change to IR35 status following review | 0 |

⁽¹⁾ The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

⁽²⁾ A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2022 and 30 June 2022:

| | |
|---|----|
| Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period | 0 |
| Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements. | 26 |

Exit packages, including special (non-contractual) payments

There were no exit packages agreed in the reporting period.

Parliamentary Accountability and Audit Report

NEL ICB is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report at page 20. An audit certificate and report is also included in this Annual Report at [\[insert page reference\]](#).

ANNUAL ACCOUNTS

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| Revenue | X |
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Statement of Comprehensive Net Expenditure for the period ended 30 June 2022

| | Note | Q1 2022-23 £'000 | 2021-22 £'000 |
|--|------|---------------------|------------------|
| Other operating income | 2 | (420) | (13,394) |
| Total Operating Income | | (420) | (13,394) |
| Staff costs | 4 | 16,386 | 56,573 |
| Purchase of goods and services | 5 | 969,358 | 3,927,457 |
| Depreciation and impairment charges | 5 | 782 | 652 |
| Provision expense | 5 | - | 8,320 |
| Other operating expenditure | 5 | 263 | 1,170 |
| Total Operating Expenditure | | 986,789 | 3,994,172 |
| Net Operating Expenditure | | 986,369 | 3,980,778 |
| Finance expense | 7 | 27 | - |
| Net Expenditure for the Period/Year | | 986,396 | 3,980,778 |
| Net Loss on Transfer by Absorption | 8 | - | 373,422 |
| Total Net Expenditure for the Period/Year | | 986,396 | 4,354,200 |
| Comprehensive Expenditure for the Period/Year | | 986,396 | 4,354,200 |

The CCG received a revenue resource limit of £986,396k for Q1 2022-23; Net Operating Expenditure was £986,396k, therefore, the CCG recorded a break-even position (2021-22, an underspend of £293k against a revenue resource limit of £3,981,071k).

Statement of Financial Position as at
30 June 2022

| | | Q1 2022-23 | 2021-22 |
|--|------|------------------|------------------|
| | Note | £'000 | £'000 |
| Non-current Assets: | | | |
| Property, plant and equipment | 10 | 1,053 | 1,149 |
| Right-of-use assets | 11 | 11,185 | - |
| Intangible assets | 9 | 43 | 57 |
| Total Non-current Assets | | 12,281 | 1,206 |
| Current Assets: | | | |
| Trade and other receivables | 12 | 29,076 | 23,561 |
| Cash and cash equivalents | 13 | - | 201 |
| Total Current Assets | | 29,076 | 23,762 |
| Total Assets | | 41,357 | 24,968 |
| Current Liabilities | | | |
| Trade and other payables | 14 | (305,751) | (373,592) |
| Lease liabilities | 11 | (1,964) | - |
| Bank overdraft | 15 | (14,319) | - |
| Provisions | 16 | (17,097) | (17,097) |
| Total Current Liabilities | | (339,131) | (390,689) |
| Non-Current Assets less Net Current Liabilities | | (297,774) | (365,721) |
| Non-current Liabilities | | | |
| Lease liabilities | 11 | (9,241) | - |
| Provisions | 16 | (907) | (907) |
| Total Non-current Liabilities | | (10,148) | (907) |
| Assets less Liabilities | | (307,922) | (366,628) |
| Financed by Taxpayers' Equity | | | |
| General fund | | (307,922) | (366,628) |
| Total Taxpayers' Equity: | | (307,922) | (366,628) |

The notes on pages x to xx form part of this statement

The financial statements on pages [] to [] were approved by the Board on [date] and signed on its behalf by:

Zina Etheridge
Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the period ended 30 June 2022

| | General Fund £'000 Q1 2022-23 | General Fund £'000 2021-22 |
|---|-------------------------------------|----------------------------------|
| Changes in Taxpayers' Equity for Q1 2022-23 | | |
| Balance at 01 April | (366,628) | - |
| Net operating expenditure for the period/year | (986,396) | (3,980,778) |
| Transfers by absorption from other bodies | - | (373,422) |
| Net Recognised CCG Expenditure for the Financial Period/Year | (986,396) | (4,354,200) |
| Net funding | 1,045,102 | 3,987,573 |
| Balance at 30 June/31 March | (307,922) | (366,628) |

Statement of Cash Flows for the period ended 30 June 2022

| | Q1 2022-23 £'000 | 2021-22 £'000 |
|--|---------------------|--------------------|
| Cash Flows from Operating Activities | | |
| Net operating expenditure for the period/year | (986,396) | (3,980,778) |
| Depreciation and amortisation | 5 782 | 652 |
| Interest paid | 7 27 | - |
| Increase in trade and other receivables | 12 (5,515) | (3,951) |
| Increase/(decrease) in trade and other payables | 14 (67,841) | 1,702 |
| Provisions utilised | 15 - | (30) |
| Increase in provisions | 15 - | 8,320 |
| Net Cash Outflow from Operating Activities | (1,058,943) | (3,974,085) |
| Cash Flows from Investing Activities | | |
| Payments for property, plant and equipment | - | (109) |
| Net Cash Outflow from Investing Activities | - | (109) |
| Net Cash Outflow before Financing | (1,058,943) | (3,974,194) |
| Cash Flows from Financing Activities | | |
| Grant in aid funding received | 1,045,102 | 3,987,573 |
| Repayment of lease liabilities | 11 (679) | - |
| Net Cash Inflow from Financing Activities | 1,044,423 | 3,987,573 |
| Net Increase/(Decrease) in Cash and Cash Equivalents | 13 (14,520) | 13,379 |
| Cash and Cash Equivalents at the Beginning of the Financial Period/Year | 201 | - |
| Transfers by absorption from other bodies | 8 - | (13,178) |
| Cash and Cash Equivalents (including bank overdrafts) at the End of the Financial Period/Year | (14,319) | 201 |

The notes on pages x to xx form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups (CCGs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCGs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

As at 30 June 2022 the CCG had net liabilities of £307,922,000.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the CCG is a going concern and the financial statements are prepared on the going concern basis.

Following the approval of the Health and Care Bill on 28 April 2022 NHS North East London CCG was dissolved on 30 June 2022. Whilst the CCG as an entity ceased to exist on that date, the activities undertaken by the CCG continued to be undertaken by NHS North East London Integrated Care Board. In accordance with the Department of Health and Social Care Group Accounting Manual, the continuation of the provision of services within the public sector means that the accounts of the CCG were prepared on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Joint arrangements

Arrangements over which the CCG has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the CCG is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

1.5 Pooled Budgets

The CCG has entered into pooled budget arrangements with the London Boroughs of Barking & Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest and the City of London in accordance with section 75 of the NHS Act 2006. These are joint arrangements in the form of joint operations.

The CCG has assessed the accounting treatment of the pooled budget arrangements having regard to IFRS10, IFRS11, and IAS28. The CCG has assessed that while joint control over the pooled budgets is present, the substance of the arrangements is that the parties to the pooled budgets are each responsible for commissioning services from providers, with the risks and rewards arising from the contractual obligation remaining with each respective commissioner. The CCG has therefore recognised in its financial statements:

- The assets it controls
- The liabilities it controls
- The expenses it incurs
- Its share of the income from the pooled budget activities

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the CCG will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The CCG is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the CCG to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the CCG is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the CCG accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

Notes to the financial statements

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the CCG commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 Property, Plant & Equipment

1.9.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the CCG;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10 Intangible Assets

1.10.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the CCG's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the CCG;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

1.10.2 Measurement

Intangible assets acquired separately are initially recognised at cost.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.10.3 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

Notes to the financial statements

At each reporting period end, the CCG checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The CCG assesses whether a contract is or contains a lease, at inception of the contract.

1.11.1 The CCG as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement of the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.12 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the CCG's cash management.

1.13 Provisions

Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

1.14 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the CCG pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the CCG.

1.15 Non-clinical Risk Pooling

The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.16 Financial Assets

Financial assets are recognised when the CCG becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

All the CCG's financial assets are categorised as Financial assets at amortised cost.

Notes to the financial statements

1.16.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the CCG recognises a loss allowance representing the expected credit losses on the financial asset.

The CCG adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The CCG therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the CCG does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the CCG becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.18 Value Added Tax

Most of the activities of the CCG are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign Currencies

The CCG's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the CCG's surplus/deficit in the period in which they arise.

1.20 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the CCG not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.21 Critical accounting judgements and key sources of estimation uncertainty

In the application of the CCG's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.21.1 Critical accounting judgements in applying accounting policies

These are the judgements, apart from those involving estimations, that management has made in the process of applying the CCG's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The CCG made no judgements in Q1 2022-23 that would have a material effect on the amounts recognised in the financial statements.

1.21.2 Sources of estimation uncertainty

These are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

The CCG had no material key sources of estimation uncertainty in Q1 2022-23.

1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 Adoption of new standards

On 1 April 2022, the CCG adopted IFRS 16 'Leases'. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.

Under IFRS 16 the CCG will recognise a right-of-use asset representing the group's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the CCG will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

The CCG has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

Notes to the financial statements

The CCG has utilised three further practical expedients under the transition approach adopted:

- a) The election to not make an adjustment for leases for which the underlying asset is of low value.
- b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
- c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

As of 1 April 2022, the CCG recognised £11.857m of right-of-use assets and lease liabilities of £11.857m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was a nil impact to tax payers' equity.

The following table reconciles the CCG's operating lease obligations at 31 March 2022, disclosed in the group's 2021-22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

| | |
|--|------------------------|
| | Total |
| | £000 |
| Operating lease commitments at 31 March 2022 | (14,050) |
| Weighted average incremental borrowing rate at 1 April 2022 | 0.95% |
| Operating lease commitments discounted used weighted average IBR | <u>(13,917)</u> |
| Less: Low value leases | 3 |
| Less: Variable payments not included in the valuation of the lease liabilities | <u>2057</u> |
| Lease liability at 1 April 2022 | <u>(11,857)</u> |

1.24 New and revised IFRS Standards in issue but not yet effective

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

The application of IFRS 17 as revised would not have a material impact on the accounts for Q1 2022-23 were they applied in that year.

2. Other Operating Revenue

| | Admin £'000 | Programme £'000 | Q1 2022-23 Total £'000 | 2021-22 Total £'000 |
|--------------------------------------|----------------|--------------------|------------------------------|---------------------------|
| Other non contract revenue | 8 | 412 | 420 | 13,394 |
| Total Other Operating Revenue | 8 | 412 | 420 | 13,394 |

Administration revenue is that which is not directly attributable to the provision of healthcare or healthcare services.

Other Operating Revenue does not include cash received from NHS England; this is drawn down directly into the CCG's bank account and credited to the General Fund.

3. Revenue

Revenue is generated wholly from the supply of services; the CCG receives no revenue from the sale of goods.

4. Employee Benefits and Staff Numbers

4.1.1 Employee Benefits

| | Permanent Employees £'000 | Other £'000 | Q1 2022-23 Total £'000 | 2021-22 Total £'000 |
|--|---------------------------------|----------------|------------------------------|---------------------------|
| Employee Benefits | | | | |
| Salaries and wages | 9,571 | 3,835 | 13,406 | 46,602 |
| Social security costs | 1,206 | 37 | 1,243 | 4,028 |
| Employer contributions to NHS pension scheme | 1,643 | 42 | 1,685 | 5,820 |
| Other pension costs | 3 | - | 3 | 18 |
| Apprenticeship levy | 49 | - | 49 | 105 |
| Gross Employee Benefits Expenditure | 12,472 | 3,914 | 16,386 | 56,573 |

4.2 Average Number of People Employed

| | Permanently employed Number | Other Number | Q1 2022-23 Total Number | 2021-22 Total Number |
|-------|-----------------------------------|-----------------|-------------------------------|----------------------------|
| Total | 662.25 | 122.53 | 784.78 | 679.71 |

4.3 Exit Packages Agreed in the Financial Period

There were no exit packages agreed during Q1 2022-23 (£nil in 2021-22).

4.4 Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating Expenses

| | Admin £'000 | Programme £'000 | Q1 2022-23 Total £'000 | 2021-22 Total £'000 |
|--|----------------|--------------------|------------------------------|---------------------------|
| Purchase of Goods and Services | | | | |
| Services from other CCGs and NHS England | 2,333 | 2,382 | 4,715 | 16,622 |
| Services from foundation trusts | - | 258,182 | 258,182 | 944,584 |
| Services from other NHS trusts | - | 428,654 | 428,654 | 1,798,182 |
| Services from other WGA bodies | - | - | - | 42 |
| Purchase of healthcare from non-NHS bodies | - | 103,033 | 103,033 | 478,635 |
| Purchase of social care | - | 8,748 | 8,748 | 46,262 |
| Prescribing costs | - | 65,085 | 65,085 | 251,551 |
| General ophthalmic services | - | 27 | 27 | 150 |
| GPMS/APMS and PCTMS | - | 88,732 | 88,732 | 340,242 |
| Supplies and services – clinical | - | 5 | 5 | 25 |
| Supplies and services – general | 10 | 1,586 | 1,596 | 11,507 |
| Consultancy services | 2 | 877 | 879 | 3,116 |
| Establishment | 279 | 4,723 | 5,002 | 17,643 |
| Transport | - | 17 | 17 | 162 |
| Premises | 420 | 2,030 | 2,450 | 13,330 |
| Audit fees | 222 | - | 222 | 240 |
| Other non statutory audit expenditure | - | - | - | - |
| - Other services | 4 | - | 4 | 18 |
| Other professional fees | 104 | 1,032 | 1,136 | 4,215 |
| Legal fees | 74 | 142 | 216 | 403 |
| Education, training and conferences | 17 | 638 | 655 | 528 |
| Total Purchase of Goods and Services | 3,465 | 965,893 | 969,358 | 3,927,457 |
| Depreciation and Impairment Charges | | | | |
| Depreciation | 568 | 200 | 768 | 595 |
| Amortisation | - | 14 | 14 | 57 |
| Total Depreciation and Impairment Charges | 568 | 214 | 782 | 652 |
| Provision Expense | | | | |
| Provisions | - | - | - | 8,320 |
| Total Provision Expense | - | - | - | 8,320 |
| Other Operating Expenditure | | | | |
| Chair and Non Executive Members | 234 | 26 | 260 | 1,094 |
| Clinical negligence | 21 | - | 21 | 38 |
| Expected credit loss on receivables | - | (18) | (18) | 38 |
| Total Other Operating Expenditure | 255 | 8 | 263 | 1,170 |
| Total Operating Expenditure | 4,288 | 966,115 | 970,403 | 3,937,599 |

Admin expenditure is that incurred which is not a direct payment for the provision of healthcare or healthcare services.

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the CCG is required to disclose the limit of its external auditors liability. The contract signed states that the liability of KPMG, its members, partners and staff (whether in contract, negligence, or otherwise) shall in no circumstances exceed £1m, aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

External Audit Fees Payable (excluding VAT)

| | Q1 2022-23 £ | 2021-22 £ |
|-------------------------|-----------------|----------------|
| Statutory audit fee | 185,000 | 200,000 |
| Other audit services | 4 | 15,000 |
| Total Audit Fees | 185,004 | 215,000 |

6.1 Better Payment Practice Code

| Measure of Compliance | Q1 2022-23 Number | Q1 2022-23 £'000 | 2021-22 Number | 2021-22 £'000 |
|--|----------------------|---------------------|-------------------|------------------|
| Non-NHS Payables | | | | |
| Total Non-NHS Trade invoices paid in the period/year | 20,839 | 254,496 | 77,173 | 969,076 |
| Total Non-NHS Trade Invoices paid within target | 20,219 | 247,869 | 73,556 | 935,553 |
| Percentage of Non-NHS Trade Invoices Paid within Target | 97.02% | 97.40% | 95.31% | 96.54% |
| NHS Payables | | | | |
| Total NHS Trade Invoices paid in the period/year | 1,147 | 728,284 | 4,198 | 2,774,110 |
| Total NHS Trade Invoices paid within target | 1,122 | 728,039 | 4,029 | 2,764,512 |
| Percentage of NHS Trade Invoices Paid within Target | 97.82% | 99.97% | 95.97% | 99.65% |

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

In Q1 2022-23 no payments were made in relation to claims under the Late Payment of Commercial Debts (Interest) Act 1998 (£nil in 2021-22).

7. Finance Costs

| | Q1 2022-23 £'000 | 2021-22 £'000 |
|-------------------------------|---------------------|------------------|
| Interest | | |
| Interest on lease liabilities | 27 | - |
| Total Finance Costs | <u>27</u> | <u>-</u> |

8. Net Loss on Transfer by Absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

| | Q1 2022-23 £'000 | 2021-22 £'000 |
|--|---------------------|------------------|
| Transfer of property plant and equipment | - | 1,655 |
| Transfer of intangibles | - | 113 |
| Transfer of receivables | - | 19,610 |
| Transfer of payables | - | (371,908) |
| Transfer of provisions | - | (9,714) |
| Transfer of Borrowings | - | (13,178) |
| Net Loss on Transfers by Absorption | <u>-</u> | <u>(373,422)</u> |

9. Intangible Non-current Assets

| | Computer Software: Purchased £'000 |
|---|---|
| Q1 2022-23 | |
| Cost or Valuation at 01 April 2022 | 284 |
| Cost or Valuation at 30 June 2022 | <u>284</u> |
| Amortisation at 01 April 2022 | 227 |
| Charged during the period | 14 |
| Amortisation at 30 June 2022 | <u>241</u> |
| Net Book Value at 30 June 2022 | <u>43</u> |
| Purchased | 43 |
| Total at 30 June 2022 | <u>43</u> |

| | Computer Software: Purchased £'000 |
|------------------------------------|---|
| 2021-22 | |
| Cost or Valuation at 01 April 2021 | 1191 |
| Disposals other than by sale | (907) |
| Cost or Valuation at 31 March 2022 | <u>284</u> |
| Amortisation at 01 April 2021 | 1077 |
| Disposals other than by sale | (907) |
| Charged during the year | 57 |
| Amortisation at 31 March 2022 | <u>227</u> |
| Net Book Value at 31 March 2022 | <u>57</u> |
| Purchased | 57 |
| Total at 31 March 2022 | <u>57</u> |

Revaluation Reserve Balance for Intangible Assets

No balance is held in the revaluation reserve for any of the Intangible Assets.

9.1 Economic Lives

| | Minimum Life (Years) | Maximum Life (Years) |
|------------------------------|-------------------------|-------------------------|
| Computer software: purchased | 1 | 1 |

10. Property, Plant and Equipment

| Q1 2022-23 | Plant & Machinery £'000 | Information Technology £'000 | Furniture & Fittings £'000 | Total £'000 |
|------------------------------------|----------------------------|---------------------------------|-------------------------------|----------------|
| Cost or Valuation at 01 April 2022 | 1,497 | 4,561 | 699 | 6,757 |
| Cost or Valuation at 30 June 2022 | <u>1,497</u> | <u>4,561</u> | <u>699</u> | <u>6,757</u> |
| Depreciation at 01 April 2022 | 1,030 | 4,200 | 378 | 5,608 |
| Charged during the period | 34 | 44 | 18 | 96 |
| Depreciation at 30 June 2022 | <u>1,064</u> | <u>4,244</u> | <u>396</u> | <u>5,704</u> |
| Net Book Value at 30 June 2022 | <u>433</u> | <u>317</u> | <u>303</u> | <u>1,053</u> |
| Purchased | 433 | 317 | 303 | 1,053 |
| Total at 30 June 2022 | <u>433</u> | <u>317</u> | <u>303</u> | <u>1,053</u> |
| Asset financing: | | | | |
| Owned | 433 | 317 | 303 | 1,053 |
| Total at 30 June 2022 | <u>433</u> | <u>317</u> | <u>303</u> | <u>1,053</u> |

| 2021-22 | Plant & Machinery £'000 | Information Technology £'000 | Furniture & Fittings £'000 | Total £'000 |
|------------------------------------|----------------------------|---------------------------------|-------------------------------|----------------|
| Cost or Valuation at 01 April 2021 | 1,940 | 4,932 | 982 | 7,854 |
| Additions purchased | - | - | 90 | 90 |
| Reclassifications | 11 | (11) | - | - |
| Disposals other than by sale | (454) | (360) | (373) | (1,187) |
| Cost or Valuation at 31 March 2022 | <u>1,497</u> | <u>4,561</u> | <u>699</u> | <u>6,757</u> |
| Depreciation at 01 April 2021 | 1,335 | 4,174 | 690 | 6,199 |
| Reclassifications | 12 | (12) | - | - |
| Disposals other than by sale | (454) | (360) | (373) | (1,187) |
| Charged during the year | 137 | 398 | 61 | 596 |
| Depreciation at 31 March 2022 | <u>1,030</u> | <u>4,200</u> | <u>378</u> | <u>5,608</u> |
| Net Book Value at 31 March 2022 | <u>467</u> | <u>361</u> | <u>321</u> | <u>1,149</u> |
| Purchased | 467 | 361 | 321 | 1,149 |
| Total at 31 March 2022 | <u>467</u> | <u>361</u> | <u>321</u> | <u>1,149</u> |
| Asset Financing: | | | | |
| Owned | 467 | 361 | 321 | 1,149 |
| Total at 31 March 2022 | <u>467</u> | <u>361</u> | <u>321</u> | <u>1,149</u> |

Revaluation Reserve Balance for Property, Plant and Equipment

No balances are held in the revaluation reserve for any of the Property, Plant and Equipment Assets.

10.1 Cost or Valuation of Fully Depreciated Assets

The cost or valuation of fully depreciated assets still in use was as follows:

| | Q1 2022-23 £'000 | 2021-22 £'000 |
|------------------------|---------------------|------------------|
| Information technology | 3,676 | - |
| Total | <u>3,676</u> | <u>-</u> |

10.2 Economic Lives

| | Minimum Life (years) | Maximum Life (Years) |
|------------------------|-------------------------|-------------------------|
| Plant & machinery | 1 | 6 |
| Information technology | 2 | 6 |
| Furniture & fittings | 4 | 7 |

11. Leases

11.1 Right-of-use Assets

| | Buildings Excluding Dwellings £'000 | Information Technology £'000 | Total £'000 | Of which: leased from DHSC group bodies £'000 |
|--|--|------------------------------------|----------------|--|
| Q1 2022-23 | | | | |
| Cost or Valuation at 01 April 2022 | - | - | - | - |
| IFRS 16 transition adjustment | 11,685 | 172 | 11,857 | 4,099 |
| Cost or Valuation at 30 June 2022 | 11,685 | 172 | 11,857 | 4,099 |
| Depreciation at 01 April 2022 | - | - | - | - |
| Charged during the period | 646 | 26 | 672 | 349 |
| Depreciation at 30 June 2022 | 646 | 26 | 672 | 349 |
| Net Book Value at 30 June 2022 | 11,039 | 146 | 11,185 | 3,750 |
| Net Book Value by Counterparty | | | | |
| Leased from other group bodies (NHS Property Services and Community Health Partnerships) | | | | 3,750 |
| Net Book Value at 30 June 2022 | | | | 3,750 |

Revaluation Reserve Balance for Right-of-use Assets

No balances are held in the revaluation reserve for any of the Right-of-use Assets.

11.2 Lease Liabilities

| | Q1 2022-23 £'000 | 2021-22 £'000 |
|---|---------------------|------------------|
| Lease Liabilities at 01 April 2022 | - | - |
| IFRS 16 transition adjustment | 11,857 | - |
| Interest expense relating to lease liabilities | 27 | - |
| Repayment of lease liabilities (including interest) | (679) | - |
| Lease Liabilities at 30 June 2022 | 11,205 | - |

11.3 Lease Liabilities - Maturity Analysis of Undiscounted Future Lease Payments

| | Q1 2022-23 £'000 | Of which: leased from DHSC group bodies £'000 | 2021-22 £'000 |
|--|---------------------|---|------------------|
| Within one year | (2,036) | (1,057) | - |
| Between one and five years | (6,715) | (2,749) | - |
| After five years | (2,772) | - | - |
| Balance at 30 June 2022 | (11,523) | (3,806) | - |
| Effect of discounting | 318 | 51 | - |
| Included in: | | | |
| Current lease liabilities | (1,964) | (1,034) | - |
| Non-current lease liabilities | (9,241) | (2,721) | - |
| Balance at 30 June 2022 | (11,205) | (3,755) | - |
| Balance by Counterparty | | | |
| Leased from other group bodies (NHS Property Services and Community Health Partnerships) | | (3,755) | - |
| Balance as 30 June 2023 | | (3,755) | - |

11.4 Amounts recognised in Statement of Comprehensive Net Expenditure

| | Q1 2022-23 £'000 | 2021-22 £'000 |
|---|---------------------|------------------|
| Depreciation expense on right-of-use assets | 672 | - |
| Interest expense on lease liabilities | 27 | - |

11.5 Amounts recognised in Statement of Cash Flows

| | Q1 2022-23 £'000 | 2021-22 £'000 |
|--|---------------------|------------------|
| Total cash outflow on leases under IFRS 16 | (679) | - |

The majority of the CCG's leases, set up as right-of-use assets with effect from 1st April 2022, relate to buildings used as administrative centres at locations across its geographical area. The most significant of these are at Unex Tower in Stratford, North House in Romford and Kirkdale House in Leytonstone. Space is also leased at a number of properties from both Community Health Partnerships (Vicarage Lane Health Centre in Stratford, Kenworthy Road Health Centre in Hackney and Beaumont House at Mile End Hospital) and NHS Property Services (St Leonards Hospital).

Two additional building leases, with West Drylining & Facades Limited and Moreland Limited, are held for the management of IT services and a lease relating to the rental of a server is held with Crown Hosting Data Centres Limited.

12.1 Trade and Other Receivables

| | Current Q1 2022-23 £'000 | Current 2021-22 £'000 |
|--|--------------------------------|-----------------------------|
| NHS receivables: Revenue | 3,391 | 8,548 |
| NHS prepayments | 8,832 | 379 |
| NHS accrued income | 2,261 | 2,487 |
| Non-NHS and other WGA receivables: revenue | 6,916 | 8,325 |
| Non-NHS and other WGA prepayments | 2,122 | 1,107 |
| Non-NHS and other WGA accrued income | 4,487 | 1,805 |
| Expected credit loss allowance-receivables | (28) | (46) |
| VAT | 1,084 | 956 |
| Other receivables and accruals | 11 | - |
| Total Trade and Other Receivables | 29,076 | 23,561 |

12.2 Receivables Past their Due Date but not impaired

| | Q1 2022-23 DHSC Group Bodies £'000 | 2021-22 DHSC Group Bodies £'000 |
|-------------------------|---|--|
| By up to three months | 1,750 | 2,645 |
| By three to six months | 1,293 | 186 |
| By more than six months | 160 | 322 |
| Total | 3,203 | 3,153 |

12.3 Loss Allowance on Asset Classes

| | Trade and other receivables - Non DHSC Group Bodies £'000 |
|--|---|
| Balance at 01 April 2022 | (46) |
| Lifetime expected credit losses on trade and other receivables-Stage 2 | 18 |
| Total | (28) |

13. Cash and Cash Equivalents

| | Q1 2022-23 £'000 | 2021-22 £'000 |
|--|---------------------|------------------|
| Balance at 01 April 2022 | 201 | (13,178) |
| Net change in period/year | (14,520) | 13,379 |
| Balance at 30 June 2022 | (14,319) | 201 |
| Made up of: | | |
| Cash with the Government Banking Service | - | 201 |
| Cash and Cash Equivalents as in Statement of Financial Position | - | 201 |
| Bank overdraft: Government Banking Service | (14,319) | - |
| Total Bank Overdrafts | (14,319) | - |
| Balance at 30 June 2022 | (14,319) | 201 |

Note 15 provides further detail for the bank overdraft

14. Trade and Other Payables

| | Current Q1 2022-23 £'000 | Current 2021-22 £'000 |
|---|--------------------------------|-----------------------------|
| NHS payables: revenue | 10,965 | 43,366 |
| NHS accruals | 15,790 | 1,427 |
| NHS deferred income | 314 | - |
| Non-NHS and other WGA payables: revenue | 35,304 | 74,022 |
| Non-NHS and other WGA accruals | 236,506 | 245,661 |
| Non-NHS and other WGA deferred income | - | 1 |
| Social security costs | 756 | 653 |
| Tax | 629 | 627 |
| Other payables and accruals | 5,487 | 7,835 |
| Total Trade and Other Payables | 305,751 | 373,592 |

Other payables and accruals include a total pension liability of £2,600,745 (2021-22: £2,412,728). This includes outstanding pension contributions for CCG employees of £732,122 as at 30 June 2022 (31 March 2022: £702,837); the balance relates to GP Pension contributions.

15. Bank Overdraft

| | Current Q1 2022-23 £'000 | Current 2021-22 £'000 |
|----------------------------|--------------------------------|-----------------------------|
| Bank Overdrafts: | | |
| Government banking service | 14,319 | - |
| Total Overdrafts | 14,319 | - |

15.1 Repayment of Principal Falling Due

| | Q1 2022-23 £'000 |
|-----------------|---------------------|
| Within one year | 14,319 |
| Total | 14,319 |

A BACS payment run was processed on 30 June 2022 as part of the preparations for the establishment of ICBs on 1 July 2022. This was posted to the CCG 2022-23 ledger, however, the cash did not clear the bank account until July 2022. This has resulted in a 'technical' bank overdraft.

16. Provisions

| | Current Q1 2022-23 £'000 | Non-current Q1 2022-23 £'000 | Current 2021-22 £'000 | Non-current 2021-22 £'000 |
|--------------------------------------|--------------------------------|------------------------------------|-----------------------------|---------------------------------|
| Continuing care | 3,414 | - | 3,414 | - |
| Other | 13,683 | 907 | 13,683 | 907 |
| Total | 17,097 | 907 | 17,097 | 907 |
| Total Current and Non-current | 18,004 | | 18,004 | |

| | Continuing Care £'000 | Other £'000 | Total £'000 |
|---------------------------------------|-----------------------------|----------------|----------------|
| Balance at 01 April 2022 | 3,414 | 14,590 | 18,004 |
| Balance at 30 June 2022 | 3,414 | 14,590 | 18,004 |
| Expected Timing of Cash Flows: | | | |
| Within one year | 3,414 | 13,683 | 17,097 |
| Between one and five years | - | 907 | 907 |
| Balance at 30 June 2022 | 3,414 | 14,590 | 18,004 |

Continuing Care

The CCG continues to recognise a provision under IAS 37 in respect of continuing healthcare retrospective claims received for activities covering periods post 1 April 2012.

The amount carried forward represents the estimated value of outstanding restitution payments still currently under review. Cases are reviewed in line with the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care guidance.

Other

A provision relating to back dated rental reimbursements for a number of GP practices comprises the majority of this category (£12,959,984).

The CCG holds a provision for dilapidations in relation to the vacating of leased office space (£1,251,410).

The remainder of 'Other' relates to a provision of £378,884 in respect of amounts due from Non EEA overseas visitors. The CCG operates a risk share arrangement with Barking, Havering and Redbridge University Hospitals NHS Trust who charge non EEA overseas visitors directly. The CCG recognises the expected amount due to the Trust as part of this risk share arrangement and this is included within note 12 of these financial statements.

17. Contingencies

A contingent liability is a potential obligation that may result, but is not likely to result because the event causing the obligation is improbable.

There were no contingent liabilities in Q1 2022-23 (£nil in 2021-22).

18. Commitments

18.1 Capital Commitments

| | Q1 2022-23 £'000 | 2021-22 £'000 |
|-------------------------------|---------------------|------------------|
| Property, plant and equipment | 464 | - |
| Total | 464 | - |

The CCG has signed a lease with Crown Hosting Data Centres Limited for an additional server and this will be set up as a right-of-use asset.

19. Financial Instruments

19.1 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the CCG is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The CCG has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG and internal auditors.

19.1.1 Currency Risk

The CCG is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The CCG has no overseas operations and, therefore, has low exposure to currency rate fluctuations.

19.1.2 Credit Risk

Because the majority of the CCG's revenue comes parliamentary funding, the CCG has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

19.1.3 Liquidity Risk

The CCG is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The CCG draws down cash to cover expenditure, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.

19.1.4 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

19.2 Financial Assets

| | Financial Assets measured at Amortised Cost Q1 2022-23 £'000 |
|--|---|
| Trade and other receivables with NHSE bodies | 3,269 |
| Trade and other receivables with other DHSC group bodies | 7,193 |
| Trade and other receivables with external bodies | 6,604 |
| Total at 30 June 2022 | 17,066 |

19.3 Financial Liabilities

| | Financial Liabilities measured at Amortised Cost Q1 2022-23 £'000 |
|---|--|
| Loans with external bodies | 14,319 |
| Trade and other payables with NHSE bodies | 3,326 |
| Trade and other payables with other DHSC group bodies | 24,161 |
| Trade and other payables with external bodies | 287,770 |
| Total at 30 June 2022 | 329,576 |

20. Related Party Transactions

Employees of NHS North East London CCG are required to disclose any relevant and material interests they may have in other organisations (related parties). This is recorded in the Register of Interests.

The transactions listed below are payments made to the related parties declared by NHS North East London CCG's Governing Body members (other than payments to practices, other NHS bodies, and other government departments):

| | Q1 2022-23 Payments to Related Party | Q1 2022-23 Receipts from Related Party | Q1 2022-23 Amounts owed to Related Party | Q1 2022-23 Amounts due from Related Party | 2021-22 Payments to Related Party | 2021-22 Receipts from Related Party | 2021-22 Amounts owed to Related Party | 2021-22 Amounts due from Related Party |
|--|---|--|---|--|--|---|--|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Parkview Medical Centre | 155 | - | 11 | - | 591 | - | - | - |
| Barking & Havering LMC | 140 | - | 70 | - | 207 | - | 140 | - |
| Bromley By Bow Partnership - based at the Bromley by Bow Centre Charity 1999 | 20 | - | - | - | - | - | 16 | - |
| City & Hackney GP Confederation | 4,061 | - | 484 | - | 14,961 | 82 | 5,836 | - |
| First Community Health and Care, Surrey | 1 | - | - | - | 3 | - | - | - |
| Greater London Authority | - | - | - | - | 35 | - | - | - |
| Havering Health Ltd | 1,438 | - | 259 | - | 5,428 | 42 | 280 | - |
| Healthbridge Direct | 2,364 | - | 192 | - | 8,264 | 25 | 1,118 | - |
| Hackney Council | 5,510 | 13 | 4,192 | 41 | 36,928 | 555 | 7,696 | 626 |
| Newham GP Federation | 2,379 | - | 1,177 | - | 8,449 | - | 1,698 | - |
| Partnering Health Ltd | - | - | - | - | 5 | - | - | - |
| Queen Mary University London | 1,385 | - | 491 | - | 1,089 | - | 1,351 | - |
| St Francis Hospice, Havering | 417 | - | 640 | - | 4,089 | - | 340 | - |
| Together First Limited (GP Federation) | 1,361 | - | 508 | - | 2,771 | 1 | 1,189 | - |
| Westlands Clinic (Langton Dental) | - | - | - | - | 12 | - | - | - |

The Department of Health and Social Care is regarded as a related party. During Q1 2022-23 NHS North East London CCG has had a significant number of material transactions (expenditure more than £1m) with the Department, and with other entities for which the department is regarded as the parent department, and NHS England the parent entity, including:

- Barking, Havering & Redbridge University Hospitals NHS Trust
- Barts Health NHS Trust
- Community Health Partnerships
- East London NHS Foundation Trust
- Guy's & St Thomas' NHS Foundation Trust
- Homerton University Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- King's College Hospital NHS Foundation Trust
- London Ambulance Service NHS Trust
- Mid and South Essex NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- NHS NEL CSU
- North East London NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- Royal Free London NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- University College London Hospitals NHS Foundation Trust
- Whittington Health NHS Trust

During Q1 2022-23 NHS North East London CCG has had a number of material transactions with other government departments and other central and local government bodies. The material transactions have been with:

- London Borough of Barking and Dagenham
- London Borough of Hackney
- London Borough of Havering
- London Borough of Newham
- London Borough of Redbridge
- London Borough of Tower Hamlets
- London Borough of Waltham Forest
- NHS Pensions
- HM Revenue and Customs

The transactions listed below are payments made to those practices where one of the GPs of that practice is or has been a member of NHS North East London CCG's Governing Body during Q1 2022-23. These payments include GMS/PMS contract and adhoc payments, but exclude prescribing payments:

| | Q1 2022-23 Payments to Related Party | Q1 2022-23 Receipts from Related Party | Q1 2022-23 Amounts owed to Related Party | Q1 2022-23 Amounts due from Related Party | 2021-22 Payments to Related Party | 2021-22 Receipts from Related Party | 2021-22 Amounts owed to Related Party | 2021-22 Amounts due from Related Party |
|---|---|--|---|--|--|---|--|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| King Edwards Medical Centre – Dr. Jagan John | 644 | - | 121 | - | 2,534 | - | 34 | - |
| Nightingale Practice - Dr. Mark Ricketts | 486 | - | 14 | - | 1,945 | - | 82 | - |
| Maylands Healthcare - Dr Atul Aggarwal | 476 | - | (7) | - | 1,906 | - | 118 | - |
| Woodgrange Medical Practice - Dr. Muhammad Waqqas Naqvi | 522 | - | 51 | - | 2,043 | - | 132 | - |
| Fullwell Cross Medical Centre - Dr. Anil Mehta | 589 | - | 164 | - | 1,993 | - | 236 | - |
| Allum Medical Centre - Dr. Ken Aswani | 754 | - | 294 | - | 2,977 | - | 332 | - |
| XX Place - Prof Sir Sam Everington | 641 | - | 151 | - | 2,453 | - | 602 | - |
| St Andrews Health Centre - Prof Sir Sam Everington | 921 | - | 177 | - | 3,733 | - | 684 | - |

21. Operating Segments

The CCG considers it has only one operating segment that being commissioning of healthcare services.

22. Joint Arrangements - Interests in Joint Operations

22.1 Interests in Joint Operations

The CCG has section 75 pooled budget arrangements with the following local authorities - London Borough of Barking and Dagenham (from 1 April 2015), London Borough of Havering (from 1 April 2015), London Borough of Redbridge (from 1 April 2015), London Borough of Newham (from 6 November 2015), London Borough of Tower Hamlets (from 1 April 2019), London Borough of Waltham Forest (from 1 April 2019), London Borough of Hackney (from 1 April 2020) and the City of London (from 1 April 2020). All the local authorities host the pooled budgets.

In line with IFRS 11 joint control over each of the pooled funds exists, however, the members of the fund have agreed to have one lead body to commission services from providers. As a result the CCG has entered into lead commissioning arrangement whereby the risks and rewards of the contractual obligations of the pool fund budgets lay with each respective commissioner.

All financial risks and rewards appropriate to the CCG are included within the Statement of Comprehensive Net Expenditure.

The CCG's shares of the assets, liabilities, income and expenditure handled by the pooled budgets in the financial year were:

| Name of Arrangement | Other Party to the Arrangement | Q1 2022-23 | | | | 2021-22 | | | |
|---------------------|--------------------------------------|-----------------|----------------------|-----------------|----------------------|-----------------|----------------------|-----------------|----------------------|
| | | Assets £'000 | Liabilities £'000 | Income £'000 | Expenditure £'000 | Assets £'000 | Liabilities £'000 | Income £'000 | Expenditure £'000 |
| Better Care Fund | London Borough of Barking & Dagenham | 2,595 | 3,921 | - | 3,921 | - | 1,524 | - | 18,041 |
| Better Care Fund | London Borough of Havering | 3,222 | 4,670 | - | 4,670 | - | 4,878 | - | 25,276 |
| Better Care Fund | London Borough of Redbridge | 3,264 | 1,471 | - | 4,870 | - | 2,442 | - | 22,934 |
| Better Care Fund | London Borough of Newham | - | 5,126 | - | 6,818 | - | 22 | - | 25,810 |
| Better Care Fund | London Borough of Tower Hamlets | - | 2,301 | - | 7,860 | - | 271 | - | 30,131 |
| Better Care Fund | London Borough of Waltham Forest | - | 2,056 | - | 5,380 | - | 5,112 | - | 20,368 |
| Better Care Fund | London Borough of Hackney | - | 2,802 | - | 6,102 | - | - | - | 23,101 |
| Better Care Fund | City of London | - | 82 | - | 211 | - | - | - | 800 |

23. Losses and Special Payments

The CCG made no special payments and incurred no losses during Q1 2022-23 (2021-22 £nil special payments; losses, 4 cases with a value of £48k)

24. Events after the End of the Reporting Period

On 28 April 2022 the Health and Care Bill was approved by Parliament. The Health and Care Bill approved the formation of Integrated Care Boards and for them to take over the functions of Clinical Commissioning Groups. As a result NHS North East London CCG was dissolved on 30 June 2022 and NHS North East London Integrated Care Board formed from the following day. In line with the provisions of the Group Accounting Manual the assets and liabilities of the CCG transferred to the newly formed Integrated Care Board at book value. Further details are provided on page x of the annual report and in the accounting policies on page x.

25. Financial Performance Targets

NHS CCGs have a number of financial duties under the NHS Act 2006 (as amended).

The CCG performance against those duties was as follows:

| | Q1 2022-23 | Q1 2022-23 | Q1 2022-23 | Duty | 2021-22 | 2021-22 | 2021-22 | Duty |
|--|------------|-------------|-------------|------|-----------|-----------|-------------|------|
| | Target | Performance | Achievement | | Achieved | Target | Performance | |
| | | | | | £'000 | £'000 | £'000 | |
| Expenditure not to exceed income | 986,816 | 986,816 | - | Yes | 3,994,555 | 3,994,262 | 293 | Yes |
| Capital resource use does not exceed the amount specified in Directions | - | - | - | Yes | 90 | 90 | - | Yes |
| Revenue resource use does not exceed the amount specified in Directions | 986,396 | 986,396 | - | Yes | 3,981,071 | 3,980,778 | 293 | Yes |
| Revenue administration resource use does not exceed the amount specified in Directions | 10,173 | 10,173 | - | Yes | 40,251 | 40,250 | 1 | Yes |

ICB Annual Report

1 July – 31 March 2023

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Abbreviations used in this report

| | |
|---------------|---|
| BHRUT | Barking Havering and Redbridge University Hospitals NHS Trust |
| ED | emergency department |
| ENT | ear, nose and throat |
| CQC | Care Quality Commission |
| CETV | cash equivalent transfer value |
| NELHCP | North East London Health and Care Partnership |
| ICO | Information Commissioners Office |
| ICB | Integrated Care Board |
| ICP | Integrated Care Partnership |
| ICPB | Integrated Care Partnership Board |
| ICS | Integrated Care System |
| IG | information governance |
| BAF | board assurance framework |
| JSNA | joint strategic needs assessment |
| NEL | north east London |
| NELFT | NELFT NHS Foundation Trust |
| NHSE | NHS England |
| PCN | Primary Care Network |
| RTT | referral to treatment time |

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PERFORMANCE REPORT

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ZINA ETHERIDGE

Accountable Officer

XX June 2023

Introduction and Performance Overview from the Chief Executive

The North East London Integrated Care Board (ICB) was established on 1 July 2022 following the disestablishment of Clinical Commissioning Groups (CCGs) and the implementation of the Health and Social Care Act 2022. This put Integrated Care Systems (ICSs) on a statutory footing and the role of the ICB is to develop a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in north east London. It must also ensure the delivery of the overall purpose and priorities of ICSs: improving quality and outcomes, securing greater equity, creating value and deepening collaboration. In addition, four core system priorities were agreed for the ICS in autumn 2021 and these are at the heart of the ICB's overall approach.

From its initial establishment the ICB has been focused on setting a number of foundations: developing an overall strategy for our partnership as well as a finance strategy, establishing a population health approach to addressing health inequalities, putting in place relevant policies, establishing and embedding the appropriate governance, developing an operating plan, ensuring co-production is core to the ICB's approach, embedding clinical and professional leadership and placing a focus on our workforce across the system. Progress is already being made across all of these areas and in collaboration with partners across the system.

One of our foundations has been embedding robust governance across the organisation and system and ensuring strong partnership working is at the core of this. The Board of the ICB is meeting regularly and membership includes partners from our NHS provider collaboratives, local authorities, primary care, community and voluntary sector partnership, along with a Healthwatch collaborative participant. Our core committees are established and meeting and our Chair Marie Gabriel CBE brings partners together across the system regularly including elected representatives' and non-executive members. We also have an established Integrated Care Partnership (ICP) joint committee with local government, with wide and inclusive partner membership, and a steering group driving the work of the overall partnership. A significant focus for the ICP has been the development of the interim five-year strategy.

The development of the [interim ICP Strategy](#) has been a significant achievement over the first six months of the ICB's establishment. A broad range of stakeholders and partners were engaged and involved in this and it outlines how we will work together in partnership to deliver our core priorities as an ICS. Co-production is a core focus for the ICB and a participation strategy 'Working with People and Communities' was agreed in collaboration with system partners and the first agreed strategy of the ICB Board. A series of 'big conversation' events are planned with residents for 2023 to ensure they are co-producing the final version of the strategy for the ICP, resulting in resident-driven success measures.

As an ICB we are committed to approaching resources in a different way and a finance strategy for the ICS is also under development, outlining how funding will be allocated across north east London with a

focus on financial sustainability and supporting all organisations and partnership forums to transform and improve services for our population. The approach will support the ICP's five-year strategy and allocate resource in line with this.

There has been a renewed focus on clinical and care professional leadership. Extensive work has taken place to develop and agree a model in partnership with clinicians and professional leads across north east London. A number of place-based clinical directors have been appointed and recruitment is continuing to ensure there is a greater diversity of professions incorporating pharmacy, Allied Health Professions (AHPs), public health, adults and children's social work and others.

At the core of our approach is ensuring we address health inequalities across the population. We have adopted the [Core 20 PLUS 5](#) approach - a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement. 'PLUS' population groups include ethnic minority communities; people with a learning disability and autistic people; people with multi-morbidities with specific consideration for the inclusion of young carers, looked after children/care leavers and those in contact with the justice system. Tackling health inequalities is a key thread through our four ICS flagship priorities and in all our work as we take a population health approach as well as improve the use of data and digital tools. Our established population health and integration committee and health inequalities steering group play a key leadership role in driving this work forward.

In the autumn we brought partners together for a series of workshops on the priorities and held one specifically on the impact of the cost of living. At this session partners shared good practice and discussed practical ways we can collaborate as a system. The winter has been a particularly challenged time with pressures on urgent and emergency care, the ongoing recovery of services as we come out of the pandemic and additional pressures from industrial action. As a system we have come together to respond to this and ensure services continue to run as effectively as possible. In response to particular pressures on our urgent care system in outer north east London, partners have been working together on an action plan and response.

Looking ahead, the focus for the next period is on further refining our strategy and embedding delivery through our joint forward plan, ensuring we develop a robust workforce strategy for the system, a comprehensive Urgent and Emergency Care plan ahead of winter 2023/24 and delivering on our financial strategy. There are a number of challenges we will manage including reductions to the running costs of Integrated Care Boards and a difficult economic picture more broadly as we manage pressures across the system. As ever, collaboration across the partnership will be key to managing this and partners are committed to working together as a system.

The first half of this report summarises the ICB's performance against our key indicators and statutory duties, highlighting where performance is strong and (for example cancer care standards) and where we are more challenged (mental health, given the system pressures). We are clear that it is only by working together as an integrated system that we will be able to improve the access, experience and outcomes for local people. Later in the section we set out the risks to delivering against our corporate objectives, again focussed on how the system can come together to support improvement.

This annual report covers July 2022 – March 2023 and is shorter due to the timeframe for approving the legislation to establish ICBs formally, but in the following sections we reflect on what we have already achieved in our first nine months.

CCG to ICB transition and financial provision

Public sector bodies are assumed to be 'going concerns' where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. When CCGs ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a going concern basis as they will continue to provide the services in the future.

The funding for 2023/24 has already been agreed with NHS England (NHSE). On this basis, there is no reason to believe that sufficient funding will not be made available in the 12 months from the date of approval of these Financial Statements.

Corporate objectives

When the ICB was formally established on 1 July 2023 a set of objectives was agreed by the board. These focused on ensuring the ICB delivered the purpose and priorities of ICSs: improving quality and outcomes, securing greater equity, creating value and deepening collaboration. A full set of strategic objectives was developed for April 2023 and progress to date is as follows:

- Prior to its establishment the shadow ICB led the system in developing a purpose, design principles and four flagship priorities, against which we would define our success. This set a framework for our agreed interim ICP strategy, and we have continued to develop this with a broad range of stakeholders and partners engaged and involved. Whilst we worked with Healthwatch in particular and our partners to gather insight we are in the midst of going out to residents and staff as part of a 'big, long and deep conversation' ahead of the final version this autumn. This conversation will further refine the content and establish people and community defined success measures.

- A finance strategy for the ICS is and has been tested and refined with partners and is now feeding in to the operating plan and work on the North East London Joint Forward Plan. This strategy ensures our focus on the [NHS Triple Aim](#) and the four aims of the ICS.
- A shared approach to population health and an approach to data and the digital infrastructure to support this, and enable us to tackle health inequalities. This includes the population health and integration committee and its reporting arrangements such as the health inequalities steering group, which is co-chaired with a Director of Public Health and the ICB Chief Medical Officer.
- Core polices have been agreed by the ICB, and ongoing work to develop and refine these and other polices continue. Just one example of system leadership has been the revised fertility policy for north east London, developed in collaboration with residents and stakeholders and ensuring an equitable approach for all local residents, removing variation.
- A robust set of governance has been established and implemented across the ICB via committee meetings and the overall Integrated care board, as well as place-based meetings and the provider collaboratives. This is ensuring decision making and discussion is taking place regularly to deliver the overall objectives and priorities for the ICB and ICS. This is supplemented by the facilitation of input by sector groupings, mandating the decision making of their representative, for example local authority leaders' meetings and Healthwatch collaborative meetings. Importantly we hold regular Board development sessions to ensure that we work effectively as a Board and as a system, furthering learning and informing strategic decision making. For example, our first focused on the role of a system unitary board and more recently we considered our system approach to improvement, facilitated by a representative of the Institute of Healthcare Improvement.
- A system operating plan is in development with the first submission complete. Further work is underway working in collaboration across the system. In addition, a joint forward plan is being developed which will be the delivery vehicle for the overall strategy. The first draft has been considered by the ICB and tested with the ICP.
- The ICS led the system, working closely with the voluntary sector, people and communities to develop a participation strategy, which was agreed at the first Board meeting. This included core principles that will guide our co-production work and which the whole system has committed to delivering. A series of big conversation events are planned with residents in 2023 to ensure they continue to co-produce the overall strategy for the ICP and define our success measures.
- A model has been developed and agreed and recruitment is underway. All the place-based partnerships and Clinical Directors were in post from late Summer/Autumn 2022. Of the 128 total positions, 106 roles have been filled, with recruitment continuing into the outstanding posts and onboarding underway. The ICB has led the system to develop a workforce strategy, with testing at Board, and connection being made across the London region to ensure we economy of scale and once for London where appropriate.

Corporate Objectives 2023-24

Building on the transitional objectives for 2023-24 and a continued commitment to delivering the core purpose of ICSs, a set of formal objectives for the board for the next financial year are proposed as follows:

1. **Implement the Integrated Care Partnership Strategy across places, collaboratives and system through the Joint Forward Plan.** This will be achieved through:

- A continued commitment to delivering on the four system priorities:
 - Babies, children and young people
 - Long term conditions
 - Mental health
 - Local employment and workforce
- A focus on six cross cutting themes:
 - Tackling health inequalities
 - Prevention
 - Holistic and personalised care
 - Co-production with local people
 - Creating a high-trust environment that supports integration and collaboration
 - Operating as a learning system driven by research and innovation
- A focus on securing the foundations of our system:
 - Improving our physical and digital infrastructure
 - Maximising value through collective financial stewardship
 - Investing in prevention and innovation
 - Improving sustainability
 - Embedding equity

2. **Deliver the NHS operational planning requirements and ensure we are delivering health and care services and effectively managing budgets** – through this plan we will ensure the elective recovery, mental health standards are met and that there is a joined-up approach to demand, especially urgent and emergency care ensuring residents get the care they need.

3. **Develop a system wide workforce strategy** - enabling all of our workforce to achieve equitable access to services to support them, and putting in place the foundations for a shared strategic plan for a workforce across north east London that meets capacity gaps, ensures we have the new skills we need for the future and provides great employment opportunities for our residents.

4. **Develop and deliver on our commitment to being an anti-racist ICS.** Further to the London wide commitment to a strategic anti-racism approach in London's Health and Care System, North East London ICB will develop a robust action plan to include anti-racism training and establishing key networks to deliver on this commitment. To help close the health equity gaps across north east London and normalise race equality into being part of how our health and care system operates.

5. **Addressing health inequalities** – through effective population health management, robust data and effective digital approaches we will address the disparities that exist across north east London and ensure that we create meaningful improvements in health, wellbeing and equity, working with and for all the people of north east London.
6. **Working as a system** - having spent this year putting in place the key enablers for the ICS, there will now be a focus on putting in place the organisational development and culture of system working, ensuring it is systematically worked through and embedded.

Strategy on research and innovation

We have developed a strategy on research and innovation which aims to support relevant local research and increase the number and diversity of people who take part in and influence our research and innovation initiatives. Over the last year we supported various research projects ranging from the impact of car emissions on asthma to developing a model of culturally tailored health care for ethnic minorities.

We have worked with NHSE and with North Thames Clinical Research Network (CRN), University College London Partners (UCLP), Healthwatch and the Voluntary, Community and Social Enterprise (VCSE) alliance towards developing an inclusive research engagement network with the aim of increasing diversity and participation in research. We have held two workshops and run a local survey which helped us better understand the possible barriers and facilitators of engaging with research.

We have also collaborated with City University and other partners for building a 'Well Communities Research Consortium' as part of which we have been exploring how local health and care systems can better interface with, develop and mobilise our community assets to improve health and reduce health disparities. We co-designed, with our link workers, digital templates and dashboards to capture social prescribing data in order to evaluate the impact of our social prescribing initiatives locally and use the data for quality improvement. We are made a strong start towards developing a learning system so that our patients and communities can shape and fully benefit from local research and innovation initiatives.

Performance analysis

Elective Services

We have an established planned care recovery and transformation programme (an integrated system programme initially set up in October 2021 to recover the elective backlog and improve equity of access for our population, led by the Acute Provider Collaborative). The programme has continued throughout 2022/23 to lead on a series of activities and interventions to manage demand, optimise existing and build new capacity.

The NEL Surgical Optimisation Group (SOG) was also established in June 2022 to bring together surgical leadership teams across the system to oversee improvements in theatre utilisation and productivity, optimisation of our designated high-volume elective hub sites and plan for an expansion in theatre capacity as a result of national targeted investment funding.

We have continued to work towards restoring elective care services back to pre-pandemic levels of activity in 2022/23. In January, inpatient activity was circa 94% of 2019/20 levels, achieved through significant effort and focus across our acute trusts, including use and maximisation of collaborative capacity and mutual aid, as well as with the support of independent sector providers. Innovation has also continued through the use of 'blitz weeks' and other initiatives to increase capacity in challenged specialties, as well as targeted work to ensure accuracy and validation of waiting lists.

A significant focus in 2022/23, in line with national ambitions, has been treating patients waiting over 2-years locally, and those that will have been waiting 18-months or more at year-end. For the latest reported month of January, we had 13 patients waiting over two years, a significant improvement from 396 patients waiting at the start of the year in April 22. The number of patients waiting 18-months or more has also seen a significant improvement from 1,519 patients in April 22 to 795 patients in January. Performance against the referral to treatment standard as reported in January was 60.4% against the 92% standard for treatment of patients within 18 weeks.

Transforming Outpatient Services

Outpatient transformation is a key programme within the overarching planned care recovery and transformation programme. The aim of the outpatient transformation programme is to create sustainable, equitable and efficient outpatient and out of hospital services to improve equity of access to elective care across NEL and reduce waiting times.

In 2022/23 focus has been on benchmarking and mapping against national best practice e.g. 'Getting it Right First Time' guidance, to identify opportunities for ongoing improvement, as well as the effective use of outpatient capacity to see patients on our outpatient waiting lists.

Increased use of referral optimisation tools (e.g. advice and guidance/refer) to provide timely advice and support to GPs and patients to manage their condition, and interventions to reduce non-value adding outpatient follow-up appointments (e.g. Patient Initiated Follow-up) have also been a key focus.

Our GPs can now receive advice directly from a number of specialist consultants, reducing hospital attendance and giving speedy care. In 2022/23 we achieved against the 16% national ask for advice

and guidance requests across 2022/23, and for approximately 29% of all outpatient appointments in January. One per cent of all outpatient attendances were moved or discharged to Patient Initiated Follow-up pathways in January with plans to increase this further in 2023/24. Where outpatient attendances are clinically necessary, around 20% were delivered remotely by telephone or video consultation.

Developmental work has also progressed in 2022/23 to ensure patients waiting for outpatient appointments in NEL are equipped with the information, support and advice they need to ensure they are able to 'wait well' via various mechanisms and tools (e.g. 'My Planned Care' online platform and the 'Waiting Well in NEL' website). These have been developed alongside an end-to-end review of pathways to ensure we have equity of access and reduce unwarranted variation in community pathway and out-of-hospital service provision for NEL residents, with conditions relating to ear nose and throat (ENT), muscular skeletal (MSK) and dermatology a particular focus. These services already exist and we know they provide an alternative service offer that reduces demand on secondary care.

Prioritising Cancer Services

The ICB supports the North East London Cancer Alliance which continues to work with acute providers, GPs, voluntary and community organisations, and the local population to increase the number of people coming forward and being referred with suspected cancer, with a particular focus on under-represented groups. More information on the work of the NEL Cancer Alliance can be found on the cancer alliance website: <https://www.nelcanceralliance.nhs.uk/>. There are three key programmes of work across the North East London Cancer Alliance, each one supported by patient engagement. These are:

Early Diagnosis Programme

- Targeted Lung Health Checks commenced in July 2022 in Barking and Dagenham. 3040 lung health checks have been completed and over 700 scans performed. Uptake rate is currently 64% against a national average of 39%.
- The 'Best for my Chest' breast screening campaign was launched in October 2022 focussing on the LGBTIQ+ community. This campaign is a collaboration with the charity Live Through This and was co-produced with members of the LGBTIQ+ community in north-east London. This was supported by sensitivity training for screening services. InHealth have requested that the training be included in their induction programmes nationwide.
- The 'It's Not a Game' campaign has continued with a focus on lung cancer awareness in November 2022. Additionally, with the Graham Fulford Charitable Foundation, free home testing kits have been made available to men over age 45, resident in north-east London. To quarter three, 226 kits had been tested, with 12 needing further follow-up (5%).

Diagnosis and Treatment Programme

- Faster Diagnosis Standard performance continues to be above the national standard.
- Implementation of the tele-dermatology project is successfully supporting providers to manage demand and reduce the backlog.
- The 'Non-Symptom Specific' pathway rollout has been completed and embedded ahead of the national expectation of 100 per cent by March 2023.
- Clinical Trial Recruitment for NEL remains one of highest in country – further work is underway to improve input from our diverse communities.

Personalised Cancer Care Programme

- All three Trusts have procured, upgraded and installed the required Somerset Remote Monitoring System (RMS). Barts Health have operationalised RMS and are “live” for colorectal and prostate patients. RMS is also “live” at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) who are moving forward with a self-management pathway for Haematology patients.
- Prehab: AHP recruitment has been successful, and all three Trusts are delivering enhanced rehabilitation services to patients. Over 300 patients have benefited from receiving prehabilitative interventions that have enabled them to be fit for treatment. An evaluation framework has been agreed.
- Completed mapping for two 'Quality of Life' priority areas as below:
 - Gap analysis of psychosocial support services across NEL and a development plan has been produced.
 - Fatigue has been identified as a priority area for Quality of Life. Mapping of fatigue and sleep services across NEL has been completed.
- Established a working partnership with Improving Access to Psychological Therapies particularly in regard to training and development of community teams.

Reducing the Backlog and Improving Performance

During 2022/23, the system focused on backlog reduction and maintaining or increasing activity levels (diagnostic, outpatients and treatments) and meeting the 28-day Faster Diagnosis Standard. Tele-dermatology is the use of digital images to diagnose, monitor or assess skin conditions without the patient being physically present. This is being used at BHRUT and Barts Health and Homerton to support increased Two Week Wait Referral and Faster Diagnosis Standard activity. The system also made investments in histology biopsy benches and workforce to support recovery of Two Week Wait Referral and Faster Diagnosis Standard.

During 2022/23, we also supported acute providers with additional funding to improve histology reporting and locum capacity was secured at Barts Health to support overall backlog recovery in 'head

and neck' treatment as well as urology tumour sites.

In addition, particular focus was on making sure people wait no more than 31 days between meeting with their doctor, at which a treatment plan is agreed, and the start of treatment. Despite challenges experienced through and since the pandemic, performance against the cancer constitutional standards has been very strong in NEL providers, meeting the July to March compliance against the:

- 31 Day First Treatment Standard with performance of 97.1% against the 96% standard.
- 31 Day Second Sub Surgery Treatment Standard with performance of 95.0% against the 94% standard.
- 31 Day Second Sub Chemo Treatment Standard with performance of 99.9% against the 98% standard.
- 31 Day Second Sub Radiotherapy Treatment Standard with performance of 98.8% against the 94% standard.

However, non-compliance was noted in:

- The Two Week Wait Referral Standard with performance of 89.73% against the 93% standard, which remains above the London average performance of 86.51%.
- Both the 62 Day Urgent GP Referral performance (59.92% against the 85% standard) and 28 Day Faster Diagnosis Standard (66.65% against the 75% standard) was challenged in recent months due to increase in dermatology referrals, histology and delayed diagnostics turnaround times.

NEL recovery action plans are in place to enable continuous improvements in the cancer position and create a better experience for our patients.

Improving Access to Diagnostics

The Alliance worked with the Mile End Early Diagnosis Centre and our three providers (Barts Health, BHRUT and Homerton University Hospital) to continue to provide additional diagnostic capacity of 16,500 procedures a year to ensure rapid investigation and diagnosis.

The Alliance also helped drive significant increase in the take up of innovations like colon capsule endoscopy – a pill containing a tiny camera that records detailed information of the colon - and cytosponge – a 'sponge on a string' pill test, which is a quick, easy alternative to endoscopy.

Rapid diagnostic centres, a single point of access to cancer tests for all patients with symptoms that could indicate cancer, are also in place in both inner and outer north east London. They are designed to speed up cancer diagnosis and improve patient experience.

The Alliance set up and is delivering the 'Targeted Lung Health Check' programme in north east London, which is providing life-saving lung scans to residents aged 55-74 who have ever smoked. Our uptake rate is 64%, one of the highest rates in the country.

King George Hospital is the first in the country to offer a robotic colonoscopy machine. Patients will benefit from a painless and non-invasive procedure compared to a traditional colonoscopy and will not require any sedation meaning faster recovery.

During 2022/23, the ICB Alliance worked with diagnostics teams with supporting the development and deployment of the national Community Diagnostics Centres (CDC) programme. This has involved achieving £6m of additional revenue funding to deliver thousands of additional diagnostic procedures, as part of the 'early adopter' programme.

We have also pressed ahead with the installation of a new MRI scanner in the Mile End Hospital, CDC and a CT scanner at Barking Community Hospital. The business cases for our potential full CDCs in Mile End Hospital and Barking Community Hospital and overall strategy for the CDCs have also been developed and provisionally agreed during this period.

NEL ICS performance against the 1% diagnostics standard (less than 1% of patients should wait six weeks or more for a diagnostic test) although still challenged has seen improvements in recent months with delivery in January at 18.61%.

In January, 9,679 patients were waiting over six weeks. This is a significant reduction compared to the 15,649 patients waiting in January 2022 and performance was at 31.13%. Improvement plans, additional capacity and activity are planned across acute and community sites to address this backlog. The ICB Alliance remains committed to the delivery of no more than 5% of patients waiting greater than six weeks by 2024/25.

Community Diagnostics Procurement – informed by local people

In August 2022, a group of 12 residents, representing a range of ages, ethnicities, gender and disabilities took part in a facilitated workshop to support the procurement of a community diagnostics service for north east London. Participants were talked through the service specification and the procurement process. It was explained that NHS North East London wanted feedback on four areas key to the service specification and procurement evaluation:

- Patient dignity and privacy
- Complaints process
- Access to support
- Patient consent and confidentiality

Attendees were split into two groups and given the four areas to discuss. Conversations were rich, with lots of helpful feedback, and we themed their comments as follows:

- Access to scans, tests and results in a timely and appropriate manner for all
- Good communication in a form that works for them with a warm welcome that is flexible around their communication needs – access to support
- Protect my data and confidentiality
- To be treated as a person, not just a 'patient' – respect and dignity
- For it to be easy and meaningful to make a complaint

This feedback informed the final service specification and shaped questions that bidders were asked as part of the formal tendering process. This meant prospective providers were tested on their commitment and experience in supporting and involving patients, maintaining confidentiality and making complaints. This will be further tested when the new provider is in place in the next few months as part of the performance management and monitoring of the new contract.

Prioritising Mental Health and Wellbeing

Mental health is a flagship priority for the ICS, with a strong provider collaborative established to work with communities and partners in all of our seven places to improve experience, access and outcomes for local people. There has been a sustained focus on expanding and improving mental health services, and services for people with a learning disability and/or autism. We know that Covid-19 has not only affected the delivery of services but has also caused an increase in demand, particularly for talking therapies, children and young people's services, severe mental health and perinatal health.

We achieved the successful rollout of the two-hour crisis community health response which ensured consistent cover (8am- 8pm, seven days a week). We have also worked with local authority, community and mental health partners to achieve a reduction in long stays, and therefore free up capacity in acute settings.

Performance for mental health standards in the first three quarters of the year has remained challenged across the board. Inappropriate out of area placement bed days for patients placed within NEL have increased across 2022, with December being at 255 bed days, compared to a 2021 average of 16, which reflects the rising levels of high acuity demand, as well as the pressure that the mental health urgent and emergency care pathway is under, as well as A&E departments. Investment is being made into additional bed capacity which should alleviate this.

Talking Therapies access remains challenged (24% against a target of 28%), although has shown a 2% improvement on the same position in 2021 (900 additional users accessing services). Similarly, for

Talking Therapies waiting times between appointments (17% against a target of 10%), although the position has deteriorated since 2021 (1,200 additional users waiting). For Children and Young People's access, the position is again challenged (46% against a 52% target), although the position remains very similar to the same point in time in 2021.

Perinatal access is also falling short of the target (7% against an 8% target), however the position has improved by 1% compared to 2021. Dementia diagnosis is also below target (60% against a 67% target), and has fallen compared to 2021 (61%). Physical health checks for people with severe mental illness (SMI) is below target (52% against a 60% target), however has shown a huge improvement compared to the same point in 2021 (41%). In 2023, a new access metric has been included, monitoring users accessing services in the community, which has planned to see 5% growth across the year (3,000 additional users accessing services).

Improving mental health services

Throughout 2022-23, we have continued to expand and improve mental health services and services for people with a learning disability and/or autism. Service users have told us that what matters is having the same range of support regardless of where they live or go to school and have worked with the system to push forward with service user/patient leadership. The plans we have put place in 2022-23 have already started to address access inequalities between boroughs and this will continue in 2023-24. Service users and carers have also stated that they want to be 'active and equal partners'. In response, we have increased service user strategic engagement within the Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative, increased peer support and, in line with our North East London strategy, have advanced new approaches to personalisation and co-production through an increased use of personal health budgets linked to co-produced digitalised care planning. Our approach has been cited as a best practice example in NHSE's Quality Framework for Personal Health Budgets.

Our priorities, co-produced with our Patient Leadership colleagues, are below:

Patient Participation/Leadership



Our mental health services have experienced rising levels of acuity in part driven by the pandemic and its aftermath, combined with the rising cost of living. This has increased the demand for crisis services and psychiatric beds. By expanding, crisis services such as crisis hubs and a clinical decision-making unit, we were able to contain, some of the pressure on psychiatric beds in the first half of the year. However, by December 2022 out of area bed placements reached 255 days compared to a 2021 average of 16 and have remained high since then. In response to these pressures, our plan for 2023-24 will ensure increased investment in mental health crisis and inpatient services. This will improve the flow within our care pathways and will alleviate some of the pressure in our Emergency Departments from mental health.

Access to Talking Therapies increased by 2% achieving a rate of 24% against prevalence. Although we did not achieve our 28% access target, plans are in place to achieve this in 2023-24 and to reduce the access inequities between boroughs. Our children and young people's mental health services have also been faced with rising levels of acuity, which has created a need to offer more crisis interventions and longer treatments. As a result, our ability to increase access rates has been challenged and we fell short of our 2022-23 target of 52% by 8%. However, plans and new investment is now in place to achieve this target in 2023-24 and also to reduce inequities in access between boroughs.

Severe mental illness (SMI) physical health check rates improved significantly from 41% (Q4 2021-22) to 65% (Q4 2022-23), with the number of service users receiving all six physical health checks

increasing by 32% since 2021-22 and there is now greater equity between places. New investment in 2023-24 will focus on outreach, peer support and health improvement. Mental Health community transformation has advanced across North East London with mental health community teams now embedded and delivering services in Primary Care Networks with a focus on severe mental illness. In 2022-23 we did not achieve the nationally set target for mental health community access (11% below plan), however we have plans in place to expand by at least 5% in 2023-24 (3,000 additional service users). Perinatal access improved by 1% against prevalence, with an increase of 15% in the number of women accessing perinatal mental health services since 2021-22, but fell short of our target (7% against an 8% target). Plans are in place to exceed 8% in 2023-24. Dementia diagnostic rates are 60% against a 67% target and the number of patients diagnosed with dementia has fallen by 9% since 2021-22. However, some boroughs are achieving the target and we plan to disseminate best practice and improve the equity between places. We are committed to a NEL wide target of 67% in 2023-24. A NEL dementia partnership model won the 2022-23 HSJ Place Based Partnership Award.

We exceeded our Learning Disability Mortality Review (LeDer) target, achieving 100%. We came very close to reaching our learning disability physical health check target, achieving 74.2% against a national target of 75%. At the time of writing, we have achieved our targets for reducing inpatient admissions for adults with a learning disability and and/or autism. Secure admissions were 19 against the target maximum of 20 and acute admissions were 14 against the target maximum of 22. Unfortunately, we exceeded the target for children and young people with 9 admissions against the target of 6. However, these appear to be driven by a recent spike in demand in one locality and we are exploring the reasons behind this. Plans are in place to build on and improve this performance and we are committed to compliance for all targets in 2023-24.

Mental Health Spend

The ICB achieved 5.82% growth in Mental Health Spend. This is 0.14% above the minimum spend requirement of the Mental Health Investment Standard. Total spend relating to this can be seen in the following table.

| Financial Years | 2021/22 | 2022/23 |
|---|----------------|----------------|
| Mental Health Spend (in scope of the Mental Health Investment Standard) | £367 | £342 |
| ICB Programme Allocation | £3,728 | £3,590 |
| Mental Health Spend as a proportion of ICB Programme Allocation | 9.8% | 9.5% |

Children and Young People (CYP) safeguarding

ICBs will have a statutory duty to safeguard children as set out in 'Working Together to Safeguard Children (2018)' statutory guidance. The NHS England Safeguarding Assurance and Accountability Framework 2022, clearly sets out safeguarding roles and responsibilities which apply to all ICBs. ICBs are required to set out how they have discharged duties in relation to child safeguarding in their annual report.

The first safeguarding children and looked after children contribution to the ICB annual report for North East London can be read on our website [here](#).

As set out in 'Working Together to Safeguard Children', 2018 ICBs are responsible for the provision of effective clinical, professional and strategic leadership in child safeguarding, including the quality assurance of safeguarding through their contractual arrangements with all provider organisations and agencies, including from independent providers. [This link](#) to the NEL ICB's confirmatory statement that demonstrates that statutory assurance processes have been implemented in accordance with the Safeguarding Accountability and Assurance Framework, 2022.

This summary outlines how the ICB has discharged its duties in relation to safeguarding babies, children and young people. In addition, it incorporates the learning from national reviews and inquiries, legislative changes as well as national safeguarding priorities.

Dissemination of learning to the system

- Shared presentation and discussion at the NEL Babies, Children and Young People forum with over two hundred health and care professionals in September 2022. The keynote speech was provided by the National Deputy director for safeguarding from NHSE.
- Ongoing learning is shared via the LSCPs, NEL Quality, Safety and Improvement Committee and associated sub-groups across the system.

Key messages for health system learning included

- Improving the effectiveness of the Multiagency safeguarding hub (MASH) provision (resource and model).
- Improving information sharing within MASH by ensuring access to health information and greater participation of the health sector.
- Promote the use of chronologies and genograms within health records.
- Introduction of multi-agency reflective practice

Leadership and culture

- Leaders have a responsibility to create working conditions to support complex work.

- There is a need to ensure: clarity of vision; responsibilities and resource; robust governance and a culture of learning, improvement and challenge.
- There should be clear management oversight of complex safeguarding work, supported by reflective supervision for practitioners.

Wider service and multi-agency context

- A failure to trigger statutory, multi-agency child protection processes.
- A rapidly evolving safeguarding agenda has overshadowed the need for sharper, *specialist* child protection skills and expertise.
- There is a need to refocus on child protection through an *expert* led, multi-agency model for child protection investigations, planning, interventions and review.

Systems and processes

- Agencies should work together to understand the lived experience of children
- There should be clear processes in place to support information sharing and information seeking, within and between agencies.
- There is a need to develop *critical thinking* and *challenge* within and between agencies.

Practice and knowledge

- The views and concerns of wider family members and those who know the child well can be too easily dismissed as malicious.
- Practitioners should appreciate the speed at which life can change and recognise the impact of change in a short space of time.
- Investigating allegations and understanding nuance when families are reluctant to engage requires great skill.
- Practitioners should sensitively support diverse communities where understanding is evolving and challenge bias – same sex couples and parenting.
- Practitioners should address the impact of domestic abuse and understand the needs of children whose parents are in prison.

NEL System response

- 'Designated Nurses' at place were tasked with developing and driving improvement plans for their areas.
- Associate Director for safeguarding children met with the national health facilitator for safeguarding reforms for the DHSC and has continued to be a member of the regional MASH Group.
- MASH assurance and quality improvement has been incorporated into reporting templates at place and system level.

- Designated nurses at place are members of the MASH Steering Groups at place and are working with safeguarding partners and borough directors on quality improvement and resourcing issues.
- Quarterly reporting to NHSE via governance heat maps keeps the issue visible.
- There are ongoing conversations with safeguarding partners regarding involvement of health in strategy discussions. Audits and appropriate reporting/data capture are under consideration with the use of appropriate escalation encouraged.
- The role of health agencies and professionals is captured in a seven-minute briefing which will be accessible to safeguarding partnerships and from our intranet and website from Q1 in 2023/24 to raise awareness among safeguarding partners.
- There is ongoing engagement with place-based partnerships regarding key issues requiring transformation and quality improvements such as MASH.
- To enable greater scrutiny the national safeguarding case tracker is being populated with information regarding Children Safeguarding Reviews (CSPRs), Rapid Reviews (RRs), Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs).
- There are many lessons to learn from the safeguarding failures in the case of [Child Q](#) both nationally and locally. The Partnership action plan is in place following the local safeguarding practice review with the City and Hackney Safeguarding Children Partnership Board overseeing its implementation of actions.

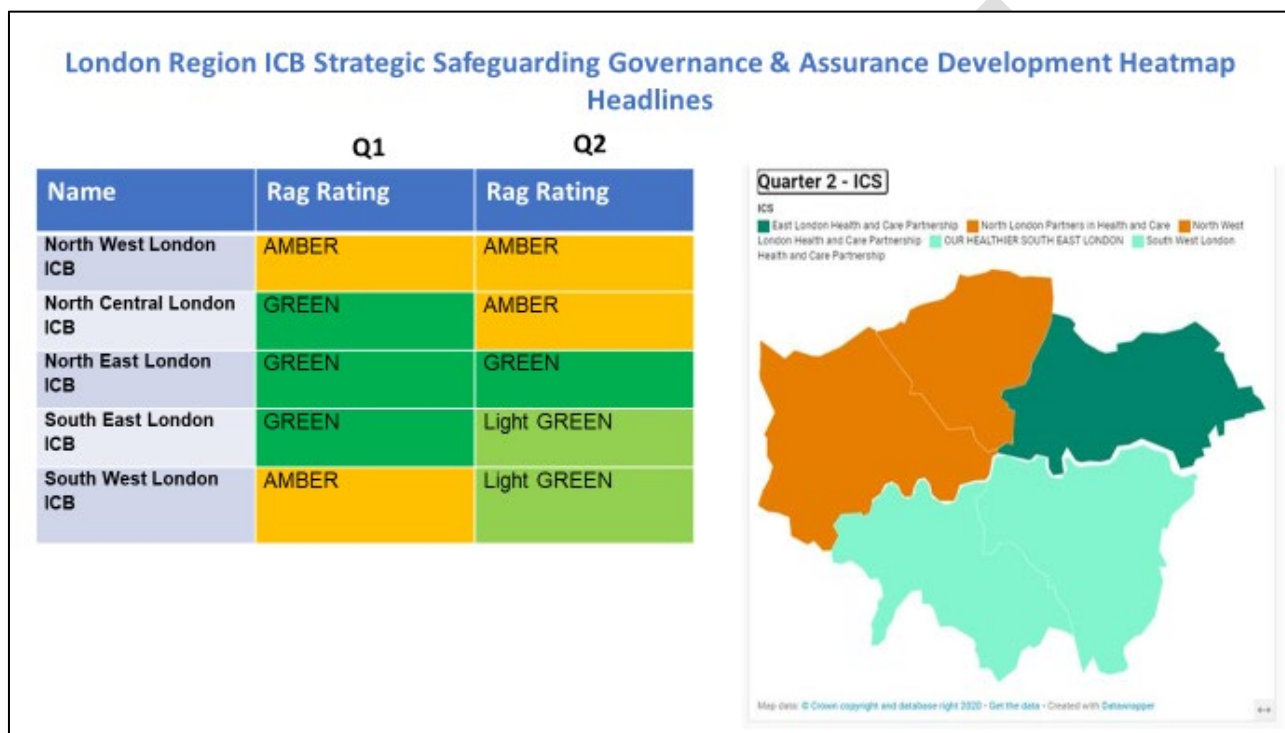
Safeguarding Assurance

During the year under review, quarterly reporting and submissions to NHS England and Improvement (NHSE) continued throughout the year. Assurance was provided via governance heat maps which enabled NHSE to assure itself regarding the preparedness of the five regional CCGs for the transition to ICBs. NEL has been consistently rated green during Q1- 3 of 2022/23. The heat maps are a matrix self-assessment tool covering:

- System leadership and accountability for action on health inequalities
- Safeguarding structures and matrix working
- Appointment of a chief nurse with executive accountability for safeguarding
- Safeguarding priorities and workplan agreed
- Partnership arrangements and understanding
- MASH information of information sharing agreements and supervision of MASH Health Team colleagues.

In addition, reporting on the safeguarding accountability and assurance tool (S-CAT) enabled an organisational assessment against the relevant domains within section 11 of the Children Act 2004 continued on a quarterly basis identifying areas requiring additional focus.

Quarterly exception and highlight reports were submitted throughout the year, which enabled formal escalation of workforce sufficiency risks for both the ICB and providers, Covid-related risks in relation to mental health and also risks associated with timely completion of statutory health assessments for looked after children and adoption medicals. Throughout the year there were periodic surges of entrants into care, driven by both Covid-impacts and also an increased number of people seeking refuge and unaccompanied asylum-seeking children (UASC) with related public health issues around health protection.



Child Protection Information sharing System in Hackney

On 12 October 2020 Hackney Council suffered a cyber-attack resulting in severe disruption to electronic systems across the council's services. The Council worked closely with the National Cyber Security Centre, National Crime Agency and other experts to investigate the attack and understand the impact on the council services and its residents.

Levels of assurance and mitigation

Colleagues in Hackney across the partnership, including safeguarding leads and designated professionals collaborated to ensure robust mitigation measures were in place, including a range of audits as requested by NHSE.

Homerton and Royal London Hospital safeguarding leads undertook two audit processes and in June 2022 Hackney CP-IS was successfully reinstated. The Child Protection Information sharing System connection to the NHS Spine was also reactivated for Hackney following the cyber-attack on their IT

system in October 2020.

Child Protection Information sharing system outage following a cyber-attack

On the 4 August 2022 the Adastra system used by some NHS unscheduled care settings was taken offline to contain a cyber security incident at the service provider. The settings within scope were:

- NHS 111
- Ambulance 111 Services
- GP Out of Hours services
- Local authorities receive Access to Service Notifications (ASNs) to a greater or lesser extent. A drop in ASNs could be seen as children's interactions with impacted NHS sites could not be recorded on Adastra during the time.

Actions taken by the NEL system:

- Mapping and scoping of affected NEL systems was undertaken to identify system risks, incident management of impacted services, workforce issues, mitigation and actions that were being implemented to manage the CP-IS access issue to assure the ICB and NHSE London Region.
- Designated professionals assisted with the development of a risk profile for the NEL system.

Female Genital Mutilation (FGM)

NEL has been part of the national FGM pilots for community clinics targeted at non-pregnant women. Formal evaluation of the pilot clinics has taken place during Quarter 3-4 of 2022/23. The final evaluation report is awaited from NHSE.

Child Death Overview Panels

There are two Child Death Overview Panels hubs across NEL. During the year and efficiency review has been commissioned and recommendations will be implemented. The Child Death Overview Panels are assurance meetings for the system and have been established to provide system oversight. These meetings and the learning from the thematic reports have identified key areas for learning in relation to sudden infant deaths although learning events have occurred at place. There is a plan for a sudden infant deaths conference in Quarter 1 -2 of 2023/24.

Looked after children and care leavers

Safeguarding children and promoting the health and wellbeing of looked after children are core duties which transitioned from the CCG to ICB. A scoping exercise to review the NEL looked after children risks was undertaken in June 2022; this desktop exercise identified a number of recurrent themes which were addressed in bi-monthly forums with a focus on quality improvement beginning from quarter two of 2022/23. Some of these recurring themes are reflected below in both the inner and the outer boroughs:

- Delays in children being seen for their initial health assessments (IHA) within 20 working days after coming into care.
- Designated Doctor for Looked after children capacity is under review due to not fulfilling the minimum requirement as per “Working Together to Safeguard Children 2018” statutory guidance.
- Equity and health inequalities are experienced by children placed out of their local area placed. Some of these are barriers to undertaking health assessments, accessing Child and Adolescent Mental Health Services and other services.

Significant backlogs for the completion of overdue Initial and Review Health Assessments (IHA and RHA) currently exist in the four outer London boroughs. The designated professionals in these places have been working with providers. Quality improvement work is in progress to address legacy risks and service delivery issues. The additional impacts of a higher number of new entrants into care during and post pandemic is also compounded by vacancies for designated doctors in some places.

A wellbeing review was undertaken in August 2022 and information from this deep dive was shared with local system chief nurses with progress updates during November 2022. Trajectories and information from the clinical harm minimisation work was also shared within NEL Safeguarding governance frameworks (NEL Quality Safety and Improvement Committee and ICB Board) in October/November 2022.

Designated professionals and NEL ICS colleagues are contributing to the development of a NEL system dashboard. It is hoped that some of the metrics proposed will provide objective assurance around the effectiveness of registered medical practitioner-initiated activity taking place following IHAs through the receipt of (at least) data on prescriptions, clinical investigations, or referrals to tertiary services. Peer review work is in progress to secure improvements to pathways.

Care leavers

The NHS long term plan commits to developing a comprehensive offer for 0-25 year olds and expectation that care leavers should benefit from improvements being made to health services. In NEL we recognise that care leavers often experience financial hardship which may impact health decisions in a context of the cost of living crisis. Our ambition is to ensure that care experienced children aged 18-25 years have access to free prescriptions.

Unaccompanied Asylum-Seeking Children (UASC)

UASC are a vulnerable group of children who are separated from their families for a variety of reasons such as forced migration, exploitation and trafficking. In NEL the best practice model in Newham, offers a 'team around the child' approach for UASC. Plans are being explored to scale up the holistic model across NEL but these are dependent on securing the requisite funding. The model utilises Health

Improvement Practitioners to co-ordinate the pathway of care for UASC in relation to the management of infectious diseases, dental, ophthalmology, Child and adolescent mental health services and emotional wellbeing resources. The model aimed at addressing inequalities in health outcomes relies on a strong interface with primary care and is underpinned by a robust academic evaluation programme.

Multiagency safeguarding arrangements

Under the [Children and Social Work Act 2017](#), three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangements to work together with relevant agencies to safeguard and protect the welfare of children in the area. The published safeguarding arrangements for each of the safeguarding partnerships within the NEL ICB footprint some of which is reflected in their annual reports for 2021/22 can be accessed via the links:

- [BHR partnership multi agency children safeguarding arrangements \(havering.gov.uk\)](https://www.havering.gov.uk)
- [Published-2223-Safeguarding-Arrangements-.pdf \(chscp.org.uk\)](https://www.chscp.org.uk)
- [THSCParrangements.PDF \(towerhamlets.gov.uk\)](https://www.towerhamlets.gov.uk)
- [Newham Safeguarding Children Partnership Published Arrangements \(newhamscp.org.uk\)](https://www.newhamscp.org.uk)
- [New arrangements for Waltham forest local safeguarding partners \(walthamforest.gov.uk/\)](https://www.walthamforest.gov.uk/)
- [Tower Hamlets Safeguarding Children Partnership \(childrenandfamiliestrust.co.uk\)](https://www.childrenandfamiliestrust.co.uk)

This summary has demonstrated how NEL ICB has fulfilled its statutory duties in relation to safeguarding children, looked after children and care leavers and outlines the NEL response areas of emerging risk, including the implementation of learning from both national and high-profile cases. In the coming year the focus will be on a number of areas which include supporting the implementation of the new serious violence duty for ICBs.

Looking at the year ahead our focus will be on strengthening safeguarding governance frameworks during the period of transition, improving workforce sufficiency and resilience. Ensuring that staff develop quality improvement skills to make a difference to experiences of children in our local population, by targeting areas of unwarranted variations to improve safeguarding and health outcomes. We will be working closely with partners including Healthwatch to embrace the opportunities presented in the new organisation for greater collaboration and integration, and to develop our safeguarding strategy.

Safeguarding adults

We appointed seven designated professionals in January 2022, who engage with wider London and national safeguarding forums, where information is then brought back to place and is shared across the system as appropriate.

The team develop relationships and contribute to a systems approach across the system which has enabled greater partnership working. They have supported primary care services by delivering safeguarding adults training and updates at Protected Time Initiative (PTI) for our GPs. These sessions refreshed practitioners around safeguarding processes, as well as updating them on tools and resources that they can use to support their safeguarding practice.

The designated professionals chair a number of safeguarding subgroups including Safeguarding Adults Review (SAR) groups. Designates work with systems partner at place to support the sharing of learning from statutory and non-statutory reviews and promote a think family focus.

[LeDeR](#) is a service improvement programme and looks to learn from the deaths of people with learning disabilities and autistic people. LeDeR reviews are carried out for all deaths of people with learning disabilities and autistic people. These reviews make recommendations to improve practice and change processes so that the lives of people with learning disabilities and autistic people, are changed for the better. There was a total of ninety-five LeDeR notifications received for 2022-23. The team work closely with the process, undertaking the function of local area coordinators and linking with system partners in the delivery and embedding of learning at place. There is an established governance group that undertakes a systems approach to the wider process.

Contribution to multi-agency and partnership working arrangements

The team engage with the 'Local Quality Surveillance Groups' to support assurance and safeguarding work in relation to care homes, supported living schemes, homecare providers, and primary care providers. This is an opportunity for ICB colleagues to come together with local authority colleagues to better understand where there may be concerns about care providers, and the work underway to support them.

The Community Safety Partnership (CSP) Boards are also attended at place as well as ad hoc workshops around the newly introduced Serious Violence Duty. The designated professionals also engage with the Safeguarding Adults Boards (SABs) and continue to support to achieve key pieces of work. In particular, to gather feedback from primary care providers for sharing purposes as and when required.

The designated professionals work closely with system partners to ensure that safeguarding remains an area of significant importance. There is close working to ensure that learning is shared and that a proactive approach is undertaken to ensure that safe and proportionate care is provided.

Examples of improvements adult safeguarding follow below:

Refugees and people seeking asylum: It has been recognised those placed in contingency hotels are at extremely high risk of exploitation and are disproportionately affected by health inequalities. In response to the safeguarding risk, the associate director for safeguarding adults, in conjunction with Redbridge Safeguarding Adult Board (SAB) chair developed a safeguarding assurance framework. This is a partnership safeguarding framework that scrutinises the partnership arrangements to safeguarding residents of the contingency hotels, as well as holds the hotel staff and delivery partners to account around their safeguarding pathways and the delivery of their safeguarding arrangements. This framework has been used successfully in Waltham Forest when the multi-agency team undertook an assurance visit at two contingency hotels. Following the visit and the use of the safeguarding framework, a robust action plan was put into place, with the outcome of increased safeguarding practices, increased safeguarding training and direct positive safeguarding outcomes for the residents of the contingency hotels.

Learning Disability: Arising from outcomes from multiple LeDeR reviews, the ICB supported the development and funding for a community liaison learning disability nurse in City and Hackney. Supporting primary care with their duties in relation to patients and residents in City and Hackney with Learning Disabilities, and leading on bespoke programs such as needle desensitisation - vaccine outreach etc. The role has been occupied for six months. Improved local outcomes have included increased delivery on the number and quality of annual health checks and subsequent health action plans for residents with learning disabilities. The focus of this role will be the uptake of cancer screening and weight management for residents with learning disabilities.

Domestic Violence: The ICB, in partnership with public health and local authority, are funding two new posts focusing on domestic violence training for staff in health care settings. The staff members also provide guidance and consultancy to healthcare workers who support people who are experiencing domestic abuse. This has directly benefited local people as staff members have felt more confident to screen for domestic abuse in emergency health care settings, identifying issues and being able to put interventions into place much earlier, for example accessing refuge placements and referring very high-risk cases to the Multi Agency Risk Assessment Conference (MARAC).

Environmental matters

We are committed to promoting economic, environmental and social sustainability through our actions as a corporate body and commissioner. We are doing this via our Anchor Charter which can be found here: <https://www.northeastlondonhcp.nhs.uk/ourplans/nel-anchor-charter.htm>. We are determined to deliver a health centred response in north east London and ensure that all of our colleagues within the ICB understand the urgent need to act.

In order to support the NHS net zero ambition, our ICS has developed a system-wide Green Plan as per

the NHS Net Zero Strategy. This plan was co-designed with stakeholders from across the system and sets out our aims, objectives and delivery plans for carbon reduction in collaboration with our ICS partners, presenting an opportunity to deliver a unified message to our staff, patients and residents across NEL. It includes four core carbon reduction targets in order to achieve net zero, with the first target of 80% carbon reduction by 2028. The NEL ICS Green Plan which is publicly available on the North East London Health and Care Partnership website <https://www.northeastlondonhcp.nhs.uk/ourplans/green-plan.htm>

In year one of the Green Plan we have:

- Formed net zero networks that link staff and leaders across the system to deliver on the aims of the Green Plan to reduce our carbon footprint by 40% by 2025
- Allocated staff to lead on net zero implementation
- Brought in over £260,000 of external funding
- Added guidance on how to consider net zero in our business case guidance
- Funded 16 places on the Royal College of GPs (RCGP) Climate Health Creation Scholarship
- Recruited four Net Zero Clinical Leads to oversee the input from Primary Care for the duration of the Green Plan
- Created a low carbon inhaler formulary
- Hosted staff sessions on active travel and joined the national Net Zero Modal Shift Network
- The ICB now provides staff with two cycle to work schemes and a low emissions vehicle salary sacrifice scheme
- Won five grants from the national Healthier Futures Action Fund
- Created a green space masterplan for the Homerton Hospital and surrounds
- Created a system-wide carbon literacy programme available to all staff from April 2023
- Committed to becoming a Fairtrade workplace.

Many staff have continued to work in a hybrid way, including remotely. This has minimised our impact on the environment through limited travel and use of consumables. We have developed and increased our ability to hold our meetings virtually, and this is set to continue through a more flexible approach to working post-pandemic.

Our procurement strategy requires us to ask providers about their approaches to sustainability and carbon reduction in the awarding of contracts. It is our responsibility to provide a minimum of 10 per cent weighting in tender scoring as per the Social Value Act. We consider and place value on local providers that can provide services and goods, as they can have associated benefits for our local population by having low emissions, job creation and local business prosperity and deliver wider local social and economic benefits. We are creating an action plan to become a London Living Wage system. Our IT and primary care teams are proactively supporting general practice to transform the way that primary care

services are more sustainably delivered, with the continued roll out and improvement in online patient consultations reducing the need for patients to travel to appointments by car or public transport.

Improve quality

Improving the quality of local health and care services is central to everything we do in north east London and indeed our work over the past year has been focussed around this. We continuously review and evaluate GP, hospital, mental health and community services to make sure they are as safe and effective as possible so that everyone, whatever their individual needs, has a good experience and easy access to excellent local services.

System working is progressing well in relation to planning for the shift from the NHS Serious Incident Framework to the new Patient Safety Incident Response Framework (PSIRF). Patient safety specialists are working collaboratively to ensure frameworks and processes are being developed to ensure we are able to learn across the System following incidents through PSIRF, thereby improving the quality of services for local residents.

Since establishing our new 'System Quality Group' so we have been able to look at wider system issues as well as focussing on issues that are specific to each borough via our new borough-based arrangements. This way of working continues to be embedded whilst also enable system conversations about how quality improvements can be made across parts of the system. We continue to embed our place quality governance arrangements and encouraging partnership conversations locally are happening to agree partnership quality priorities based on what the Place-based Partnerships identify as the key areas to improve for their resident. We will continue to drive improvements and outcomes for our residents through these groups.

We continue to make progress in development and implementation of our System Quality Framework and recognise the complex nature of enabling this total system way of working across all partners will take time. We have made good progress in ensuring the work of our NEL ICS Local Maternity and Neonatal System (LMNS) works through the Acute Provider Collaborative specifically in making the improvements needed in our maternity services.

Examples of improving quality with partners and people in NEL

- **Realignment of Discharge Funding**

Additional funding to support discharge was given to ICSs to support the system pressures that have been felt nationally. The funding is allocated on an outdated formula which does not take into the large demographic changes in North East London. This meant more pressurised places and pathways would receive less funding than other areas. The system came together with Director of Adult Services from across North East London to agree a new formula and realign

funding to areas of most need. This would not have been possible without the ICS, ICB working across multiple local authorities. The outcome of this is that North East London has the best discharge rates in the whole of London even though has one of the most pressurised acute services.

- **Avoidable Admissions**

One of the key focus for places is to 'Keep People Well at Home' where possible. One of the main ways to do this is ensure citizens are supported in the community and are not admitted to hospital where this can be avoided. North East London ICB led work on understanding the flow across NEL between all practices, communities and acute hospitals. The data showed clear outliers within the system (acute sites and GP Practices) meaning work can now be targeted in two specific Boroughs and one main hospital site. This work will see a reduction in avoidable admissions by up to a third in outer London. The ICB has also invested in growth monies to support this work. If this was not an ICB wide piece of work there may have been a blanket support which would not have targeted the areas of most need and have the impact that has been modelled.

- **Core Connectors**

As part of the national Core 20 plus 5 programme, core connectors is a key element where local people from communities of need are trained and supported to be advocates and signpost local people to health services, offer support and translate health messages. This programme has been piloted in one of the most deprived areas in Havering following a successful national bid. The programme recruited people who are refugees, homeless and those living with physical and mental long-term conditions. As well as supporting hundreds of local people accessing health and wellbeing services, this programme has also benefited the volunteers. One volunteer who was homeless now has found accommodation and is now working freelance in making promotional videos, another volunteer who is a refugee is applying to university and will be gaining work experience in a local pharmacy, one other volunteer is now applying for work as a community development officer. This programme is planned to be rolled out across Havering in other areas of need. This work has been developed in partnership with the ICB, local authority and the voluntary sector.

- **Cost of Living support and Warm Hubs**

The ICB has led system wide work on understanding the cost of living impacts on the health and wellbeing of people across North East London. NEL has the most diverse populations in England so the impact of the many communities on the cost of living challenges is stark. System wide workshops were held where good practice was shared across the system as well as data shared on potential impacts. This work is now adopted and delivered in each place in partnership with local authorities and voluntary sector. This has seen the ICB support and fund work such as warm hubs and grants for those who have expensive medical equipment, Other pieces of work include developing a risk tool with local authorities on linking household finance risks with health

risks. This approach has been used to target households with packages of support such as energy doctors and falls prevention. This is the ICB working in partnership with local Place partnerships to ensure support is 'upstream' and preventative.

Clinical leadership

The ICB led an extensive programme of work to redesign the clinical and care professional leadership model for the ICS taking account of national guidance and the development of place based partnerships and provider collaboratives. A recruitment process was undertaken to establish all of the new roles in the new model and we now have a more inclusive and diverse leadership structure in place including strategic leads on areas such as research and innovation, population health management and health inequalities. We appointed Clinical Directors in all of our seven place-based partnerships, primary care development leads and clinical/care professional leads.

As part of the engagement process to develop our ICP strategy, we held a number of system wide workshops bringing clinicians, care professionals and other leads together with service users to develop our system priorities. These were in mental health, babies, children and young people, and long-term conditions. We also held similar workshops with clinical/care professional input around key strategic issues such as the cost of living increase and health inequalities. The strategy work included development of a population health profile for our system which had extensive public health input.

We established a Clinical Advisory Group (CAG) chaired by our Chief Medical Officer which brings together our most senior clinical leaders to provide advice to our ICB Board. The CAG was kept informed of the development of the strategy and participated in the sign off process.

We are also establishing a clinical and care professional forum to bring together a wider group of clinical and care professional leaders across the ICS to input into our programmes and also to act as a development space for building capability around key priorities such as population health management.

Engaging people and communities

Our NEL ICS strategy for Working with People and Communities 2022-2025 was developed in collaboration with our partners, engagement leaders from across ICS organisations, public forums and groups and local people. It was the [first strategy agreed](#) by our new ICB Board, reflecting our commitment to participation as a right for all people in north east London. It sets out our vision to ensure participation is at the heart of everything we do. This is rooted in a set of co-designed principles for participation, which are grouped under five overarching themes:

- Commitment
- Collaboration
- Insight and evidence

- Accessibility
- Responsiveness

Representatives from both the voluntary and community sector and our local Healthwatch organisations are fully embedded in our governance structures, with places on our Board - a VCSE collaborative member as full member and a Healthwatch collaborative member as a participant attendee providing constructive input and challenge. These colleagues are also members of key committees and working groups – for example all Healthwatch and VCSE umbrella bodies are on the ICP committee, with reps on the smaller steering group – equal to statutory partners.

North east London has many innovative examples of patient and community leaders being provided with training and working alongside us as partners, including the model developed by our mental health learning disability and autism colleagues cited earlier in this report. A proposal for a NEL ICS community leadership programme is currently being co-developed with input from across the system, drawing on existing best practice.

We successfully bid for NHSE funding and support to establish a VCSE collaborative in NEL. The leadership group has made positive progress, with a further commitment from the ICB to fund the next stages of development for the collaborative.

We fund an innovative community insights system, led by our eight local Healthwatch, which has received national attention. Our recent case study is cited here as a model of best practice: [Community Insights – Local Voice](#)

We have been working closely with our place based partnerships to support their governance arrangements, and to ensure that they are co-producing with our people and communities, with Healthwatch as members of each along with VCSE reps. For example, we have clear processes in Newham for local residents to put forward their experience of the health system at board-level. These discussions have directly led to shifts in service design, including reaching out to deaf residents who experience significant barriers to access healthcare services following a patient story. A partnership-wide piece of work is underway with deaf residents which has three workstreams: commissioning, primary care and learning and feedback. As a prelude to this work the partnership has reviewed all departments within Newham University Hospital and confirmed all have access to SignLive and BSL interpreters, however, this has highlighted training needs internally for staff to understand how to access the provision, which is something we are now working on. We will work across the ICS and with our people and communities to deepen our collaboration.

Building on the collaborative working during the development of the strategy, a Steering Group to oversee the strategy will meet from April 2023, and in addition to this, the first meeting of a NEL ICS Participation and Co-Production Community of Practice/Network will come together in the summer. This builds on a session we held with our chief participation and place officer, chief executive and incoming regional director of NHSE London region where partners leading on innovative co-production models exchanged information and ideas about their projects and how we could embed this approach further in NEL. This led to a further in-depth workshop session at our ICP committee meeting, for which an action plan is being pulled together.

In Tower Hamlets, work is underway to embed coproduction within the work of the place-based partnership. A task and finish group is chaired by a member of the community and involves representatives from the Council, NHS, local universities, the VCS and the community. Alongside our partners in Barking and Dagenham, Havering and Redbridge, our Health and Faith Network continues to bring together faith leaders from across the three boroughs to support our work. The network has been sharing important messages, such as videos we have co-produced with our faith community for Ramadan, via WhatsApp, which has been shared with over two thousand local Muslim people.

In the lead up to the Babies, Children and Young People strategy workshop in November 2022, a number of sessions took place with partners across the system to understand children's health priorities both at NEL and at Place, building on existing work and conversations over the last 18-24 months. The workshop itself saw more than 200 attendees, and we continue to engage with our 600 strong stakeholder list with a fortnightly newsletter.

The maternity equity and equality strategy and action plan was published in December 2022. This piece of work saw engagement with over 1000 women and pregnant people and their families, as well as maternity advocates, via online surveys, face to face interviews and focus groups. This engagement was particularly focused on women from Black, Asian and Ethnic Minority backgrounds and those living in the most deprived areas as detailed in the NHSE guidance. The engagement work was led by Healthwatch across all our boroughs and supported by Maternity Mates. The [full report, summary report and plan on a page](#) have been shared with stakeholders and presentations has been delivered to several groups, from provider collaboratives to faith-based community events.

End of life care in Waltham Forest and Redbridge is undergoing transformation, linked to the redevelopment of Whipps Cross Hospital. In order to inform initial service proposals, engagement leads across ICS partner organisations in Waltham Forest and Redbridge (NHS North East London, Barts NHS Health Trust and NELFT) have worked together to ensure the views of residents are reflected within these service proposals. Due to the sensitive nature of the topic, independent experts were

commissioned to carry out a first phase of engagement that included confidential interviews with people from across Waltham Forest and Redbridge who are experiencing life limiting conditions or bereavement. Commissioning these experts removed any bias from conversations. Commissioning a specialist organisation also allowed for interviews to be carried out in community languages if the participant did not speak English as their first language. Interviews and focus groups were held with community stakeholder groups who support people with a life-limiting condition or support carers. These groups included community funeral directors, charities supporting people with lifelong conditions and action groups. Information was used to compile a [full report](#), which was used to inform the development of a set of initial service proposals for end of life care transformation. A second phase of more in-depth engagement with local people will be carried out in Spring and Summer of 2023.

The City and Hackney System Influencers is a group of ten local young people recently recruited to work in collaboration with a cross section of system projects, including Homerton University Hospital, the local Neighbourhoods partnership and Public Health. The System Influencers are worked collaboratively with local professionals who acted as mentors. The System Influencers co-designed the projects. Examples of the work include co-designing and delivering workshops around healthy weight with public health, and co-designing focus groups for local young people around access to services for the Neighbourhoods programme. The System Influencers ensured the questions and content of the sessions were designed in a way that was accessible to young people. Findings will inform local services. Two of the young people involved have now progressed into paid roles within the health and care system as a direct result of the skills and experience gained. This project was co-managed by the Children and Young People Transformation Programme and Healthwatch Hackney. A project manager was recruited from the pool of young people that have previously volunteered with the system. Funding has been approved for another iteration of the programme, which will be a twelve-month programme supporting thirty young people.

We will gather insight and evidence to inform our priorities and target our participation efforts

The NEL Community Insights System, developed and managed by our NEL Healthwatch, is a valuable tool which we continue to develop. The Community Insights System currently holds over 80,000 comments from local residents that equates to approximately 280,000 separately coded issues. Insights on inequalities has allowed the ICB to focus on customising communications to meet the needs of particular ethnic and disability groups leading to better uptake of immunisation and screening programmes. A series of bespoke reports also informed the development of our system wide ICP integrated care strategy. We have a well-established People's Panel with over 2,500 local people signed up. We are going through a period of refresh and will be working with panel members to codesign how a new platform could work.

In Havering, our volunteer community connectors within our Core20plus5 programme as mentioned earlier in the quality section have been busy engaging with over 400 residents gathering feedback about health and care services.

We recognise the need to embed Accessibility Information Standards further across the system so we are developing an Accessibility Champions Programme which will draw on practice system-wide. Champions will be recruited from staff and their roles will be to ensure that our communications consider the accessibility requirements of our diverse population.

In July, the ICB board heard some powerful personal insights on accessing services from two profoundly Deaf residents. Their experiences were mirrored across primary care, acute and Mental Health Trusts and at local authority level. Engagement staff to set up a working group bringing together partners, user-led organisations and people who are deaf or hard of hearing to build on best practice and co-produce solutions. For example, in Redbridge there are plans to form a dedicated working group which will plan to address health inequalities faced by the deaf community and residents with accessibility needs.

Key to accessibility is developing opportunities for people to participate in a way that works for them. Here are some examples of innovative ways we have reached different groups.

- Targeted Lung Health Check: Working across our diverse communities to achieve one of the highest uptakes in the country, we have now scanned more than 2,000 residents in Barking and Dagenham, and we are now looking to expand the programme to other areas. We have produced a video which is available in 17 different languages: Targeted Lung Health Check Videos. Find out more: <https://www.nelcanceralliance.nhs.uk/tlhc>
- Best For My Chest: This is designed to help the LGBTIQ+ community come forward for life-saving breast screening appointments. It is the result of twelve months engagement with the LGBTIQ+ community to identify the issues faced by those accessing Breast Cancer Screening. Local people volunteered to become champions for the campaign, and they have played a central role in designing key messages, posters and graphics. Read a testimonial from a volunteer: <https://www.nelcanceralliance.nhs.uk/best-my-chest-testimonial>

We will ensure that the impact of participation is clear to people, communities and partners. The East London Women's Experience Forum continues to provide an opportunity for maternity staff and maternity advocates from community and voluntary organisations to ask questions, hear information and updates from each of the NEL maternity units and share experiences of those women and pregnant people they advocate for or represent.

We are working with partners to develop a consistent approach to patient stories and case studies, both in terms of how we share these amongst partners but also how they are communicated at Boards and

committees and how we are evidencing action taken based on the feedback.

Working with our Primary Care Networks

We continue to provide advice, insight and support to our primary care community, and are committed to supporting our Primary Care Networks (PCNs) to improve how they listen to residents and communities.

In July, we supported our PCNs to seek the views of their patients to feed into their enhanced access service offer. The team worked with them to create a patient survey which was sent out via text message and received over 30,000 responses. Members of the communications and engagement team then sat in on panel meetings where their proposed plans were presented. This gave us the opportunity to challenge how they had considered patient feedback within their plans.

We will support PCNs across north east London in their work with practice Patient Participation Groups (PPGs), which will create more opportunities for local people to be involved in the work to build healthier neighbourhoods.

Provider collaboratives and participation

Provider partners were involved in developing the Working with People and Communities strategy and next steps, ensuring that the principles and ambitions will also drive the work of our collaboratives.

Work is well underway within all of the collaboratives across north east London to consider how they will involve and listen to local people and communities. The MHLDA has established advanced arrangements in regard to service user and carer leadership – with local people developed, rewarded and supported to play a full role in the alliance, the sub-committee and wider governance.

In addition to our proactive engagement through social media, local project liaison and newsletters we continue to engage with key stakeholders through regular meetings e.g. with Healthwatch, with MPs and health overview and scrutiny committees and joint health overview and scrutiny committees.

We have set clear foundations in our initial months of operation, with our strategy setting out some clear deliverables for next year:

- In June we start the Big Conversation with local people to build on what they told us during the development of the ICP strategy. The activities will take place in different formats as we are conscious of the needs of our diverse population. We will work with local people to define the success measures for delivery of our strategy – ensuring that these are meaningful and impactful for local people. We will also explore the key issues affecting local people and how we could use our health and care budgets differently in future, aligned to their priorities.

- We are developing a system wide, consistent Reward and Recognition policy to support us to remove barriers to participation by having a clear offer of how we reimburse expenses and where applicable, offer involvement payments.
- To truly embed our principles of co-production and participation and ensure that participation is everybody's business, we are developing our training and development opportunities for staff. This is starting with development of an e-learning module, in partnership with local people, which will clearly set out the vision of engagement across NEL, expectations of our staff and support available.
- To support work across the ICS we are developing a Community of Practice which will bring together engagement leaders across the footprint to collaborate, showcase best practice and share insight.
- Local people are working alongside us to develop a Community Leadership Programme so that we fully embed a co-production approach across the organisation, including corporate services.

Polio vaccine take-up case study

The NHS had to vaccinate as many 1–9-year-old children against Polio as possible, after the virus was unexpectedly found in London sewage samples. This was a brand-new programme that started in August 2022 and by the time it ended in December 2022 we had vaccinated over 82,300 children – the highest number in London. This was a significant achievement given uptake of other vaccines is generally low in the area, and we are taking learnings forward into current and future vaccine drives.

We devised a public information campaign with trusted information, persuading parents to come forward to get their children vaccinated at their GP surgery or vaccination centre. The campaign needed to be agile so it could be mobilised rapidly, given the fast-moving public health situation.

Our strategy was to initially drive awareness so people understood the need to come forward while GPs and vaccination centres prepared to scale up to deliver this, and then to drive action and encourage people to get vaccinated once mass vaccinations were available.

The campaign needed to be inclusive given the region is home to some of the UK's most diverse communities, with high levels of deprivation and low English language levels. It prioritised the boroughs of Newham, Waltham Forest and Hackney, given risk levels and numbers of children.

A one-size-fits-all approach wasn't possible. Instead, we used a combination of:

- Conventional mass comms for informing parents, such as regional TV news opportunities, organic social media, paid social media and paid adverts on search engines.
- Direct comms to parents, including letters from schools to parents, text messages to parents, information to GPs so they could have conversations with their patients

- Tailored, community-driven and grassroots comms, including developing WhatsApp messages that community leaders could share, multilingual leaflet drops in local libraries and low uptake areas, and community champions going out to spread the word in the community.

We devised our own materials where we could. We used local networks to spread the word, including community champions and faith leaders. We also used innovative channels and platforms to raise awareness, including news updates on a parenting app called Baby Buddy.

The instant brand recognition and instinctive trust people have for the NHS was used to full effect, alongside trusted community voices. This included a local polio survivor whose [powerful testimony was picked up in local media](#) and helped persuade parents.

“Vaccination is the best way to protect children and stop the virus spreading. Otherwise, you risk catching polio and living a limited life with limb damage, pain, fatigue and muscle weakness. I wouldn’t wish that on anyone.” – Mahfuzur Rahman

NHS North East London outperformed all other organisations by the total number of children vaccinated (82,300 – the London average was 64,000).

Funding boost for health and care research

We secured nearly £100,000 of national NHS funding to support the development of a research engagement network. The new network will drive the work of ICS partners to encourage greater public participation in research across NEL and ensure it reflects the diversity of local communities – helping them tackle health inequalities and shape services around people's needs. We worked closely with North Thames Clinical Research Network, UCL Partners, Healthwatch and the local voluntary community and social enterprise alliance.

Reducing health inequality

People’s chances of enjoying good health and a longer life are not equal. They are determined by the social and economic conditions into which they are born and live their lives (which also make a difference to the way people use health services and look after their own health). These different conditions create avoidable health inequalities, which can only be addressed through action across society.

There is widespread collaborative action to tackle health inequalities at place level, close to local communities. Local health and wellbeing strategies consider the changing health and social care needs of the population, as set out in the local joint strategic needs assessment (JSNA) and identify key

priorities, which then underpin service planning. Place-based partnerships bring together key health and care partners, and focus on addressing health inequalities in all that they do.

Some examples of our achievements so far include:

- Digital champions for each place to support digitally excluded patients to access digital NHS services aligning with local authority work on digital inclusion.
- Women's Health Hub pilots bringing care closer to home and streamlining services to improve access and prevent multiple appointments.
- Analysis of trust elective waiting lists resulting in successful actions to reduce inequalities in waiting times experienced by people with a learning disability.
- Targeted campaigns and projects to reduce inequalities in cancer prevention, awareness and screening, to prevent cancer and increase early diagnosis.
- NEL anchor charter and collaborative action, e.g. Health and Employment Hub supporting 750 underrepresented local people into work.
- NEL maternity equity and equality needs assessment, strategy and action plan to improve outcomes for those from minority ethnic backgrounds and deprived areas.
- Developing understanding of the health needs of our population through the NEL population health profile, and developing capability and capacity to address these.
- Mobilising tobacco dependence services and alcohol care teams in our hospitals.

As a learning system we are building on best practice. For example, Waltham Forest commissioned University College London Institute of Health Equity to review health inequalities in the borough and make recommendations. ELFT is also a Marmot Trust. We are currently exploring the system implications of this review. Another example is the community chest for social prescribing developing across all places, increasing capacity for support through the voluntary, community, faith and social enterprise sector to address health inequalities. Places are leading on activity to reduce health inequalities through work ranging from long term condition case finding, to fuel poverty and debt support, to child vaccinations and health literacy.

Recognising and building on delivery and expertise at the local level, addressing health inequalities is a responsibility of every part of the system and this is reflected in its inclusion as one of six cross-cutting themes of the interim strategy. Our North East London ICS Financial Strategy also demonstrates our commitment to addressing health inequalities through its focus on sustainable approaches to levelling up and reducing gaps across our geography.

A Population Health and Health Inequalities Steering Group provides strategic leadership to embed population health and health equity across all parts of the system. The steering group oversees four workstreams: population health management; equity in health and care services; embedding prevention;

and anchor system. Delivery of these is through our wider system including place-based partnerships and collaboratives. The approach includes activity against the Core20Plus5 for adults and children and young people (the approach defines a target population cohort - the 'Core20PLUS' - and identifies '5' focus clinical areas requiring accelerated improvement).

Health and wellbeing (HWB) strategies

Our local authority and place-based partners work together across all of our place-based partnerships and through our ICB sub-committees. The new freedoms to work together in integrated partnerships locally ensures that our health and wellbeing and local partnership strategies are now more joined up than ever, read more on our website: www.northeastlondonhcp.nhs.uk/aboutus/north-east-london-integrated-care-system.

Below are just some of the examples from our partnerships about some of the positive work underway locally to realise the ambitions in each of the HWB strategies.

Pathway Team

The Pathway charity has developed a national model of complex care coordination to meet the health, housing and social care needs of people experiencing homelessness when they attend or are admitted to hospital. The Homerton and City and Hackney Centre for Mental Health Pathway team pilot commenced at Homerton hospital in January 2022, and extended to the City and Hackney Centre for Mental Health in May 2022. The current hospital team comprises a part time GP, full time nurse, occupational therapist and housing worker (seconded from Hackney Council). All members of the team are utilised in the case management of clients.

The service has been supported throughout by a Peabody Housing Association six bedded Lowri House 'step down' facility, exclusive to the team, which opened in January, and two housing support workers (provided by Providence Row), both grants funded by the Out of Hospital Care Models (Homelessness) Fund provided by the Office for Health Improvement and Disparities.

In the first year, 335 referrals were received by the Pathway team and the team accepted 304 (94%). 97% of these accepted referrals were assessed within two working days, with an average waiting time from referral to assessment of only 3.5 hours. 27 patients went to Lowri house.

Patient feedback

- 'They were very reassuring. They came to see me when they said they would, and did what they said they were going to do. You don't always get that.'
- 'I loved her, she was really fighting my corner, I felt like she was really on my side.'
- 'So many people are homeless - we need specialist services like them – they are a big help.'

Staff and partner feedback

- 97% said the team were either 'Extremely Helpful' or 'Very Helpful'
- "The work the team do is to such a high standard, it goes a long way to reduce the risk and really turn a hospital admission into an opportunity for change and increased safety for homeless individuals."
- "Without the Pathways team - my client would not have received the adequate level of care. The Pathways team were easily contactable, they communicated and managed the discharge well."

Improving patient experience for deaf residents

Introduced in 2016, the Accessible Information Standard (AIS) was established to give people with a disability or sensory loss the right to receive information in a way they can understand and communication support they need. The NHS and adult social care services must comply with AIS, but evidence shows we are not yet compliant in Redbridge. This was illustrated through a powerful resident story at the first meeting of the ICB board from a couple based in Redbridge. Through engagement sessions with deaf residents, consultations with deaf charities, and national research, the Redbridge Place Based Partnership has highlighted the following issues within the partnership:

- Lack of deaf awareness amongst frontline staff.
- Severe unreliability in access to British Sign Language interpreters.
- Lack of ownership of issue across the system.
- Receiving phone calls from GP practices, hospitals and the local authorities.
- Lack of access to Covid-19 information throughout the pandemic, including the vaccine programme.
- Some clinicians telling British Sign Language users to bring family along to interpret which is not appropriate, particularly if dealing with confidential or personal information.
- Inaccurate information from London Borough Redbridge employees advising that it is not possible to get interpretation for appointments.
- Engagement forums and community activities are not accessible without a British Sign Language interpreter.

In response to this, the partnership has actioned the following:

- An improved level of understanding and training of AIS.
- Commissioned British Sign Language interpreted videos on key health topics such as winter vaccinations and mental health, which have been shared with local groups and the partnership.
- Committed to implementing 'Sign Video' in the Council.
- Established relationships and partnership working with Royal Association for Deaf People, Sensory Specialists, Healthwatch and Empowering Deaf Society for local BSL requirements and further insight.

- Tested the new Newham Language Shop British Sign Language service.
- Commissioned a series of health engagement sessions specifically tailored with support from Sensory Specialists, designed to share key health messages with deaf residents and answer their questions with an interpreter present.
- Discussions with our digital team about how to follow best practice model and make the website more inclusive.

A key part of this work has been our Healthy Redbridge: British Sign Language sessions. In these sessions, around users living in Redbridge have access to specialists from across the partnership to learn, ask questions, and share feedback. The themes for each session were defined by the specific health needs and knowledge gaps in this cohort of residents, and are on the following:

- Mental Health
- Getting Active
- Cancer and Cancer Screening
- Diabetes and Healthy Eating
- Sexual Health
- Smoking and Alcohol

The engagement sessions are just part of a wider project to implement AIS and make Redbridge fully accessible to those with disabilities and sensory loss. Specifically relating to British Sign Language or future model will:

- Make access to BSL interpreters for residents easier and enhance web accessibility via tools such as 'SignVideo'
- Implement/develop flagging systems to easily identify residents with accessibility requirements to GP practices and council services.
- Implementing screens (or other accessible methods) for patients to make them aware a professional is available to see them.
- Mystery shop with GP practices and local services to see how accessible services are to residents.
- Address the cost of living crisis through engagement activities with the community including translated videos, community engagement sessions and easy read material.
- Work with partnership organisations to align complementing workstreams in accessibility.

Iford Exchange health centre engagement work

In September 2022, Redbridge partners launched a consultation on plans to create a new health centre in Ilford town centre. The proposals for this new health centre would provide space for primary, community and social care services from two floors in the Ilford Exchange shopping centre in the heart of Ilford, close to main amenities and transport links. The services proposed for the new health centre

included, GP services, Health and Adult Social Care Team (HASS), health visiting and school nursing team, community blood testing, mental health support services and Long-term conditions.

As part of the proposals there may also be additional space with flexibility for other seasonal services and potentially some community space on which residents were invited to share their views. The consultation took place over six weeks and included a public survey; an information stand for two days in Ilford Exchange managed by people who speak multiple languages; four public engagement events and one engagement event with members of the local charity One Place East who have different disabilities. Printed versions of the survey and an easy read guide survey were also available. The consultation was also widely promoted through various community groups which ensured that the demographics of those who responded were as representative as possible of Ilford. NHS North East London, NELFT and London Borough of Redbridge worked closely together to deliver the consultation as part of the Redbridge borough partnership which allowed for a wider reach into the community.

The response to the plans for the new health centre from local people and stakeholders was overwhelmingly positive. A full [report of the findings](#) was developed and presented to the Ilford Exchange task and finish group who reviewed the suggestions and produced a [consultation response](#).

Understanding and managing risk

The ICB agreed a risk management policy and strategy at its inaugural meeting on 1 July 2022 to ensure the organisation manages its key risks and supports staff to manage risk effectively. There have been a number of Board discussions on risk to develop and agree its approach to risk including risk appetite and its board assurance framework. The most recent board assurance framework was agreed by the board on 29 March 2023 and is included in the board papers here <https://northeastlondon.icb.nhs.uk/events/north-east-london-icb-board-meeting-4/>. The board assurance framework aligns to the strategic aims and objectives of the ICS and covers the following key areas with further details on the mitigations of these risk described below:

Collaborative working across partners - 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.

Mitigation: established involvement from ICP system partners to oversee development and drafting of the strategy which was socialised in forums across the ICS including Health and Wellbeing Boards, Place Based Partnerships, Healthwatch and CVS.

Quality and safety of care - 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.

Mitigation: established a system quality group to escalate clinical issues across system partners which included Chief Nurses and Chief Medical Officers to develop plans to request additional clinical support across the system and possible redirection of clinical support, ensure after action review and clinical harm review processes and recommendations are implemented.

The ICB Quality, Safety and Improvement Committee regularly reviews the impact of industrial action and ensures system programmes are developed to support urgent and emergency care improvements. Delivery against control total and operating plan - 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.

Mitigation: established an ICS Chief Finance Officers meeting with all system partners with outcomes agreed including:

- Providers have been given additional funding for elective care (Elective Recovery Fund – ERF)
- System-wide discussions are taking place to discuss the drivers of the deficit, via the financial recovery summit and system finance groups
- System wide formal recovery programme to be stood up with key groups to take forward different areas of recovery; including workforce productivity, corporate services and temporary staffing.
- System partners have internal efficiency programmes in place to deliver savings for this financial year
- 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
- Within the ICB - development of CIP and recovery plans for continuing health care (CHC) and prescribing.

Following further system wide discussion, we have also included a more recent risk in relation to digital and estates as follows: 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.

Mitigating actions are currently being worked through across our wider partnership.

Financial review

As at 31 March 2023 North East London Integrated Care Board (NEL ICB) had net liabilities of £307.7m (£307.9m as at 30 June 2022 and £366.6m as at 31 March 2022).

The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCGs). ICBs took on the commissioning functions of CCGs; CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

When CCGs ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

The funding for 2023/24 has already been agreed with NHSE. On this basis, there is no reason to believe that sufficient funding will not be made available in the 12 months from the date of approval of these Financial Statements.

Financial performance

In the 9 months to the period end 31 March 2022/23 NEL ICB was given funding of £3,186.1m from NHSE and received £18m of other non-contract income (Total £3,204.1m). Within this funding the ICB is allowed to spend £33.7m on the running costs of the organisation.

The majority of the ICB's spend is used to purchase services from NHS Trusts and NHS Foundation Trusts. In the 9 months to the period end 31 March 2022/23 we spent £2,193m (£686.8m in Q1 2022/23 and £2,742.8m in 2021/22), which is 69% of our total spend this is consistent with Q1 2022/23 and 2021/22.

The ICB delivered a small surplus of £0.04m for the 9 months to the period end 31 March 2022/23. The ICB has also remained within the running costs allocation.

The financial position continues to be very difficult and so in 2023/24 we have a challenging financial plan. The ICB is working collaboratively with partners across the system to deliver the actions and

mitigations required in relation to the challenging financial position.

The financial statements contained within the report provide a summary of the ICB's financial position and performance for the 9 months to the period end 31 March 2022/23. This section of the report talks about how we manage our money and how our financial performance is measured.

We are accountable for how we spend public money and achieve good value for money for our patients. This is the first year of North East London Integrated Care Board, and good financial control and management is vital for the development of the organisation.

Funding

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How we spent the money

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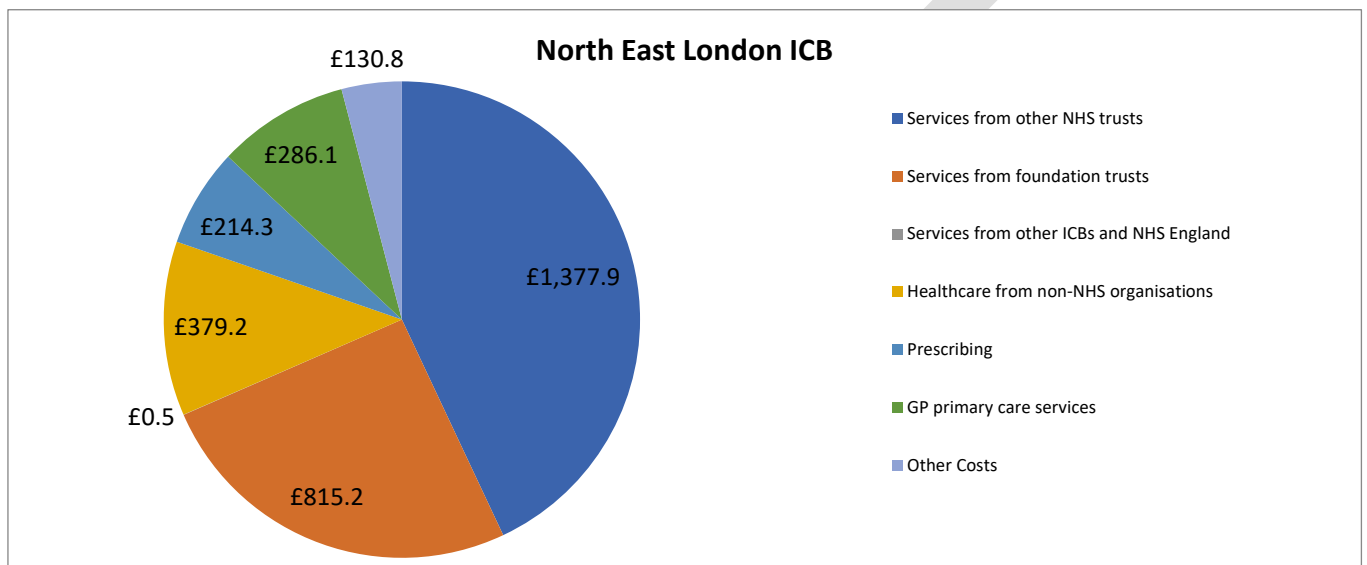
In the nine months to the period end 31 March 2022/23, spend related to delegated co-commissioning arrangements totalled £287.2m (£90.3m in Q1 2022/23 and £350.8m in 2021/22). This equates to 9% of the ICB total spend and remains in line with the Q1 2022/23 and 2021/22.

In summary we spent the money as follows:

| | £'000 | % |
|--|----------|-------|
| Services from other NHS trusts | £1,377.9 | 43.0% |
| Services from foundation trusts | £815.2 | 25.4% |
| Services from other ICBs and NHS England | £0.5 | 0.0% |

| | | |
|---------------------------------------|------------------------|--------|
| Healthcare from non-NHS organisations | £379.2 | 11.8% |
| Prescribing | £214.3 | 6.7% |
| GP primary care services | £286.1 | 8.9% |
| Other Costs | <u>£130.8</u> | 4.1% |
| | <u>£3,204.0</u> | 100.0% |

How we spent the money



Overall Financial Performance

During the 9 months to the period end 31 March 2022/23 NEL ICB has worked under the national financial arrangements which includes block contracts with NHS providers, specific funding for COVID 19 services, elective recovery and a greater emphasis on financial planning at an Integrated Care System level.

The ICB delivered a small surplus of £0.04m for the 9 months to the period end 31 March 2022/23. The ICB has also remained within the running costs allocation.

Financial pressures

The ICB has faced a range of financial challenges across the year mainly impacted by Inflation, Continuing Health Care (CHC), Hospital Discharge Pathway, Prescribing and Independent Sector Contracts along with demand growth in areas such as Mental Health.

Future years

Regulators have confirmed the NHS has a fixed level of ICB funding for the financial year 2023/24 which will cover the locally agreed and NHSE set block contract values for NHS providers. The financial

position continues to be very difficult and so in 2023/24 we have a challenging financial plan. The ICB Chief Finance and Performance Officer (CFPO) has constituted a finance recovery working group across the whole of the ICS. This group will review and drive forward the financial position, efficiency and savings targets and oversee the development of a 5-year system financial plan.

DRAFT

ACCOUNTABILITY REPORT

DRAFT

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Zina Etheridge

Accountable Officer

XX June 2023

Accountability Report

Corporate Governance Report

Introduction

As the system convener, the ICB worked with system partners to design inclusive, collaborative and effective structures and processes for governance. In doing this we focused on building shared ambition, mutual accountability with decision making principles intended to deepen collaboration. These principles were agreed by the new Board and are at the front of each board agenda pack. We have a comprehensive [Governance Handbook](#), which sets out our arrangements in full. We have tested, learnt from and adapted our arrangements throughout the year.

In advance of this, while we were in shadow form and establishing the ICB, we worked with the wider system and integrated care partnership to develop [key design principles to guide our work, agreeing four flagship priorities and a shared ambition](#): “We will work with and for all the people of north east London to create meaningful improvements in health, wellbeing and equity”.

Composition of ICB Board

The ICB Board (the Board) is comprised of nominated members from partner organisations, including healthcare and local government, and officers who have the duty to ensure the ICB exercises its functions effectively, efficiently and economically. The Board is responsible for ensuring that the ICB meets all its financial obligations, including accounting and auditing and performing its functions in a way which provided good value for money.

Detailed information regarding the members can be found on our [website](#) and below. Information about the work of the Board is contained in the Governance Statement.

| Name | Title and/or role |
|--------------------|-------------------------|
| Marie Gabriel CBE | Chair |
| Zina Etheridge | Chief Executive Officer |
| Diane Herbert | Non-executive Member |
| Imelda Redmond CBE | Non-executive Member |

| Name | Title and/or role |
|--------------------------|---|
| Cha Patel | Non-executive Member (from 1 February 2023 to date) |
| Sue Evans | Associate Non-executive Member (Interim Board member from 8 September to 31 January 2023) |
| Rajiv Jaitly | Non-executive Member (from 1 July 2022 to 7 September 2022) |
| Diane Jones | Chief Nursing Officer |
| Dr Paul Gilluley | Chief Medical Officer |
| Henry Black | Chief Finance and Performance Officer |
| Dr Jagan John | Partner Member (Primary Care) |
| Dr Mark Rickets | Partner Member (Primary Care) |
| Paul Calaminus | Partner Member (NHS trusts and foundation trusts) |
| Shane DeGaris | Partner Member (NHS trusts and foundation trusts) |
| Councillor Maureen Worby | Partner Member (Local Authority) |
| Mayor Philip Glanville | Partner Member (Local Authority) |
| Caroline Rouse | Partner Member (Voluntary, community and social enterprise sector) |

Meetings were also attended regularly by the following people who are not voting members of the Board, but are part of the ICB's executive management team and leaders within the Integrated Care System.

| Name | Role |
|----------------------|---|
| Charlotte Pomery | Chief Participation and Place Officer |
| Francesca Okosi | Chief People and Culture Officer |
| Johanna Moss | Chief Strategy and Transformation Officer |
| Andrew Blake-Herbert | Local Authority Executive Participant |
| Manisha Modhvadia | Healthwatch Participant |

In addition, we have a number of associate non-executive members, appointed on a shorter-term basis, who were formally engaged with the CCG and have supported the transition to the

new organisation, supporting with continuity and organisational memory from a non-executive perspective.

Committee(s), including Audit Committee

The ICB's Audit and Risk Committee members are detailed below and more information about the committee and its work is contained in the Governance Statement.

Audit and Risk Committee

| Name of member | Role |
|-----------------------|---|
| Cha Patel | Non-executive Member (Chair of the Committee from 1 February 2023) |
| Sue Evans | Associate Non-executive Member (Interim Chair of the Committee until 31 January 2023) |
| Noah Curthoys | Associate Non-executive Member (from 7 October 2022 to 28 December 2022) |
| Kash Pandya | Associate Non-executive Member |
| Imelda Redmond CBE | Non-executive Member |

Membership details of other committees is also contained in the Governance Statement.

Register of Interests

North East London ICB published a register of Board members' interests on the [website](#) which was updated as and when changes were notified to the ICB. The register gives details of company directorships or other significant interests held by members and senior managers where those companies were likely to do business, or possibly seek to do business with the NHS, where this may conflict with their managerial responsibilities.

Personal data related incidents

NEL ICB maintains an approved Information Governance (IG) Framework which includes a suite of approved IG policies and an annual evidence-based response to the NHS mandated Data Security and Protection Toolkit which covers 113 standards relating to the processing of personal data for both patients and staff. These standards include training a minimum of 95% of our staff annually on information governance and data protection and operating IG and data sharing groups to oversee our controls for how we manage and share personal data. The ICB operates a privacy by design approach and considers new projects and technology which process personal data using a Data Protection Impact Assessment (DPIA) to ensure that appropriate controls are implemented and risks mitigated.

The ICB maintains and promotes an internal incident reporting and management process which includes incidents which involve loss of data (personal data breach), breaches of the Data Protection Act and UK GDPR and inappropriately shared data. We notify the Department of Health and Social Care and the Information Commissioner's Office (ICO) of serious incidents that require investigation which meet the reporting threshold set by DHSC and ICO via the national IG incident reporting tool.

During the reporting period, the ICB had no serious incidents involving data loss or confidentiality breaches which met the requirement for formal reporting to the ICO.

Modern Slavery Act

NHS North East London fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the North East London Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and

Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England. NHS England has appointed the Chief Executive Officer to be the Accountable Officer of North East London Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the North East London ICB's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that North East London ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

NHS North East London Integrated Care Board (NEL ICB) is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended). The NEL ICB's statutory functions are set out under the National Health Service Act 2006 (as amended). The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population. Between 1 July 2022 and 31 March 2023, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NEL ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my

responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NEL ICB's Accountable Officer Appointment Letter. I am responsible for ensuring that the NEL ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Board is to ensure that the ICB has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

The Constitution

The Constitution, which was approved by NHSE as part of the authorisation process in July 2022 provides that it is the ICB Board which undertakes any functions not reserved or otherwise delegated.

ICB governance structure

The ICB governance structure was created to ensure that health and care system partners and local residents are at the heart of decision making whilst delivering on the ICS priorities agreed by the Board in July 2022. The governance structure reflects the fact that there is a shared management team and operating model supporting seven place-based partnerships and provider collaboratives whilst maintaining the functions of the ICB in its own right as a statutory body with overall accountability.

ICB Board

Meetings were held in venues across the north east London footprint and members of the public were invited to join in person or online and, as always, to submit questions in advance.

Recordings of the meetings are available via the ICB's website.

The key areas of focus for the ICB Board at the meetings held between July 2022 and March 2023 were:

- a. Approving the governance handbook
- b. Approving the 'Working with People and Communities Strategy'.
- c. Reporting on co-production with local residents in the work of the ICS
- d. Development of the integrated care strategy
- e. Development of the ICS workforce strategy
- f. Development and agreement of the finance strategy

- g. Development and agreement of the Joint Forward Plan
- h. Reporting on the delegation of pharmacy, optometry and dental services
- i. Reporting on and oversight of ICB and ICS finances
- j. Reporting on and oversight of performance and quality issues within commissioned health providers
- k. The management of strategic risk through scrutiny of the Board Assurance Framework (BAF)
- l. Compliance with ICB statutory duties
- m. Exception reports from the committees of the Board.

The membership and attendance record of the ICB Board is outlined in the table below:

| ICB Board member | 1 July 2022 | 28 Sep 2022 | 30 Nov 2022 | 25 Jan 2023 | 29 March 2023 | Total attended /total possible |
|--|-------------|-------------|-------------|-------------|---------------|--------------------------------|
| Marie Gabriel CBE | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| Zina Etheridge | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| Paul Calaminus | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| Shane DeGaris | ✓ | ✓ | ✓ | ✓ | X | 4/5 |
| Maureen Worby – from September 2022 | N/A | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Philip Glanville – from September 2022 | N/A | ✓ | X | ✓ | ✓ | 3/4 |
| Caroline Rouse – from September 2022 | N/A | ✓ | ✓ | ✓ | X | 3/4 |
| Diane Jones | ✓ | ✓ | ✓ | ✓ | X | 4/5 |
| Henry Black | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| Dr Paul Gilluley | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| Dr Mark Ricketts | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| Dr Jagan John | X | ✓ | ✓ | X | ✓ | 3/5 |
| Diane Herbert | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| Imelda Redmond CBE | X | ✓ | ✓ | ✓ | ✓ | 4/5 |

| | | | | | | |
|--|-----|-----|-----|-----|-----|-----|
| Rajiv Jaitly – from 1 July 2022 to 7 September 2022 | ✓ | N/A | N/A | N/A | N/A | 1/1 |
| Cha Patel – from 1 February 2023 | N/A | N/A | N/A | ✓ | ✓ | 2/2 |
| Sue Evans – from 8 September 2022 to 31 January 2023 | N/A | ✓ | ✓ | ✓ | N/A | 3/3 |

The meeting was also attended regularly by:

- Will Tuckley, local authority executive participant (until 2 March 2023)
- Andrew Blake-Herbert, local authority executive participant
- Manisha Modhvadia, Healthwatch participant observer
- Francesca Okosi, Chief People and Culture Officer
- Johanna Moss, Chief Strategy and Transformation Officer
- Charlotte Pomery, Chief Participation and Place Officer

Committees of the ICB Board

The Board has authority under the scheme of delegation to establish committees or sub groups to enable it to fulfil its role. Each of the Board committees has terms of reference and the roles of each are set out broadly below. Each committee is authorised by the Board to pursue any activity within their terms of reference and within the scheme of reservation and delegation of powers.

Executive Committee

The Executive Committee oversees and takes any relevant decisions in line with the principles which have been agreed by the ICS partners, set out [here](#). The Committee also prioritises delivery against the agreed strategic priorities of the ICS set out [here](#).

The duties of the Committee are to:

- Provide executive oversight of the preparation and delivery of the Integrated Care Partnership (ICP) Integrated Care Strategy, the associated joint forward plan, and the joint capital resource use plan, ensuring delivery of key commitments, objections and milestones.
- Develop and recommend to appropriate partner organisations for approval related strategies for discrete areas for implementation across the ICS area.
- Provide executive oversight of the ICS system budget and financial delegations to ensure delivery of system control total and financial improvement trajectory.
- Ensure opportunities for bidding for transformational funding are maximised and provide oversight of bids.

- Oversee system quality and safety, receiving updates and assurances from the NEL System Quality Group.
- Oversee delivery of the NEL People Plan and any workforce issues, receiving updates and assurance from the NEL People Board.
- Recommend to the Board and provide executive oversight of adherence to policies.
- Provide executive coordination of strategy and system response to incidents and emergencies, including in relation to the ICB's duties under section 252A of the 2006 Act and by virtue of being a category 1 responder under part 1 of the Civil Contingencies Act 2004.
- Drive forward the ICB's commitment to continuous development and improvement. Programmes
- Oversee delivery against the ICS programmes of work, including urgent and emergency care and specialised commissioning.

The membership and attendance record of the Executive Committee is outlined in the table below.

| Name of committee member | 16 Nov 2022 | 12 Jan 2023 | 9 Feb 2023 | 9 March 2023 | Total attended /total possible |
|--|-------------|-------------|------------|--------------|--------------------------------|
| Zina Etheridge (Chair), CEO NHS North East London | ✓ | ✓ | X | ✓ | 3/4 |
| Andrew Blake-Herbert, Chief Executive, London Borough of Havering | ✓ | X | ✓ | ✓ | 3/4 |
| Louise Ashley, Chief Executive Officer, Homerton Healthcare NHS Foundation Trust | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Henry Black, Chief Finance and Performance Officer, NHS North East London | ✓ | X | ✓ | X | 2/4 |
| Paul Calaminus, Chief Executive Officer, East London NHS Foundation Trust | ✓ | ✓ | ✓ | X | 3/4 |
| Shane DeGaris, Group Chief Executive, Barts Health NHS Trust | ✓ | ✓ | X | X | 2/4 |

| | | | | | |
|--|-----|---|---|-----|-----|
| Dr Paul Gilluley, Chief Medical Officer, NHS North East London | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Gladys Xavier, Director of Public Health, London Borough of Redbridge | ✓ | X | ✓ | ✓ | 3/4 |
| Heather Flinders, Strategic Director of People, London Borough of Waltham Forest | ✓ | X | X | ✓ | 2/4 |
| Jacqui Van Rossum, Acting Chief Executive Officer, North East London NHS Foundation Trust | X | ✓ | ✓ | X | 2/4 |
| Diane Jones, Chief Nursing Officer, NHS North East London | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Johanna Moss, Chief Strategy and Transformation Officer, NHS North East London | ✓ | X | ✓ | ✓ | 3/4 |
| Francesca Okosi, Chief People and Culture Officer, NHS North East London | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Charlotte Pomery, Chief Participation and Place Officer, NHS North East London | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Sarah See, Managing Director of Primary Care, NHS North East London | N/A | ✓ | ✓ | X | 2/3 |
| Tim Aldridge, Corporate Director of Children and Young People, London Borough of Newham | ✓ | ✓ | X | X | 2/4 |
| Matthew Trainer, Chief Executive, Barking, Havering and Redbridge University Hospitals Trust | ✓ | X | X | X | 1/4 |
| Will Tuckley, Chief Executive, London Borough of Tower Hamlets (until 2 March 2023) | ✓ | ✓ | X | N/A | 2/3 |

The following key topics were discussed by the Committee 2022/23:

- The Integrated Care Strategy
- The Joint Forward Plan
- Delegation of pharmacy, optometry and dental services
- Monthly position of ICB and ICS finances
- 2023/24 Operating Plan
- Delegation of specialised commissioning
- Emergency Preparedness, Resilience and Response workplan
- Place partnership mutual accountability framework
- Making north east London a London living wage place

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- A positive approach to partnership working
- Professional input into discussion
- Clear commitment to make a difference and outcome focused

Areas for improvement:

- Increasing the number of items requiring decision
- Further development is needed to include social care on agenda items
- Meetings in person could improve working relationships

The Clinical Advisory Group (CAG) is a sub-committee of the Executive Committee, the details of which are outlined below.

Clinical Advisory Group

The Clinical Advisory Group (CAG) is a sub-committee of the Executive Committee of the North East London ICB. The CAG provides strategic clinical leadership and guidance across the ICB, to inform the ICB's decisions. It may receive recommendations from the Senate to inform its work. Its key remit is to provide clinical and care professional evidence-based advice and make recommendations on service transformation for issues which impact across the ICB footprint.

The duties of the advisory group are to:

- Approve the work plans and priority setting for the pan-NEL Clinical Networks.
- Make clinical recommendations on transformation proposals which has an impact on the ICB's area, defined as any proposal which has an impact on more than one Place.

- Provide a clear interface between the London-wide clinical advisory arrangements and NEL-wide decision making.
- Review London Clinical Advisory Group ('LCAG') guidance and determining the implications for implementation across NEL.
- Maintain effective dialogue with LCAG, notifying them of any specific issues from national level guidance that may need further review at NEL level.
- Provide professional clinical and care leadership across NEL, leading engagement with health and care professionals within organisations and the wider Clinical Senate.
- Provide strategic level clinical and care professional opinion on transformation proposals.
- Develop clinical/care led solutions where appropriate and make recommendations to the ICB for consideration or when escalation is required.
- Review the potential opportunities for improvement and rationalisation of health and care services in NEL based around the agreed principles of patient safety, improved outcomes for local people and better value for money.
- Ensure the system develops robust proposals that are safe and effective and that the reasons underpinning financial assumptions are clinically sound.
- Highlight risks regarding quality of care, safety and deliverability of plans, and support any mitigating actions which can be taken.
- Identify opportunities for new clinical pathways.
- Ensure that health and care colleagues and the wider ICS are kept informed about the CAG's work and are engaged as appropriate.

The membership and attendance record of the Clinical Advisory Group is outlined in the table below.

| Name of Committee member | 01 Mar. 2023 | 29 Mar. 2023 | Total attended /total possible |
|---|--------------|--------------|--------------------------------|
| Dr. Paul Gilluley, Chief Medical Officer, NHS North East London – Chair | x | ✓ | 1/2 |
| Diane Jones, Chief Nursing Officer, NHS North East London | ✓ | X | 1/2 |
| Raliat Onatade, Chief Pharmacist, NHS North East London | ✓ | ✓ | 2/2 |
| Dr Ramneek Hara, Clinical Director | ✓ | ✓ | 2/2 |
| Dr Stephanie Coughlin, Clinical Director | ✓ | ✓ | 2/2 |
| Dr Rima Vaid, Clinical Director | ✓ | ✓ | 2/2 |

| | | | |
|--|---|---|-----|
| Dr Anil Mehta, Clinical Director | ✓ | ✓ | 2/2 |
| Dr Ken Aswani, Clinical Director | ✓ | ✓ | 2/2 |
| Dr Deblina Dasgupta, Clinical Director | ✓ | ✓ | 2/2 |
| Dr Mark Rickets, Inner North East London Primary Care Representative | ✓ | ✓ | 2/2 |
| Dr Jagan John, Outer North East London Primary Care Representative | ✓ | ✓ | 2/2 |

The meeting is regularly attended by:

- Rachel Dalton - Group director of Allied Health Professionals, Barts Health
- Fiona Kelly - Director of AHPs, ELFT
- Patrick Brooks - Systems Partnership Transformation Manager - North East London, London Ambulance Service

The following key topics were discussed by the Committee in 2022/23:

- Terms of reference
- Clinical and Care Professional Advisory Group for Whipps Cross discharge framework
- IPC Updates
- Clinical and care professional leadership

Some of the areas that the Group had requested more detailed reports on in the form of 'deep dives' were: Inequalities in access to secondary and tertiary care.

Audit and Risk Committee

The purpose of the Audit and Risk Committee is to contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the ICB board on the adequacy of governance, risk management, internal control processes and arrangements to manage conflicts of interest within the ICB.

The duties of the Audit and Risk Committee are to:

- Provide assurance and advice to the ICB board on the following:
 - The proper stewardship of resources and assets including value for money
 - Financial reporting
 - The effectiveness of audit arrangements both internal and external
 - Risk management
 - Control and integrated governance arrangements within the ICB

The membership and attendance record of the Audit and Risk Committee is outlined in the table below.

| Name of Committee member | 21 Sept 2022 | 7 Dec 2022 | 1 Feb 2023 | 15 Mar 2023 | Total attended /total possible |
|---|--------------|------------|------------|-------------|--------------------------------|
| Cha Patel, Chair and Non-executive member (from 1 Feb 2023) | N/A | N/A | ✓ | ✓ | 2/2 |
| Sue Evans, Associate non-executive member (covered the role of Interim non-executive member and Audit Chair until 31 Jan 2023) | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Imelda Redmond CBE, Non-executive member | X | ✓ | ✓ | ✓ | 3/4 |
| Kash Pandya, Associate non-executive member | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Noah Curthoys, Associate non-executive member (Member during Dec 2022) | N/A | ✓ | N/A | N/A | 1/1 |

The meeting is regularly attended by:

- Henry Black - Finance and Performance Chief Officer, NHS North East London
- Steve Collins – Executive Director of Finance, NHS North East London
- Sunil Thacker – Director of Finance, NHS North East London
- Rob Adcock – Finance Director, NHS North East London
- Marie Price – Director of Communication and Involvement, NHS North East London
- Dean Gibbs/Carl Van Den Berg– External Auditor, KPMG
- Nick Atkinson/John Elbake – Internal Auditor, RSM
- Mark Kidd – Local Counter Fraud Specialists, RSM

The following key topics were discussed by the Audit and Risk Committee in 2022/23:

- Governance
- Risk management
- Internal control
- External Audit
- Internal Audit
- Counter Fraud
- Procurement and contracts
- Information governance and IT
- Financial reporting
- Pharmacy, optometry and dentistry delegation

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Comprehensive agendas and reports and well chaired
- Effective scrutiny and engagement with internal and external audit
- Return to face to face meetings has helped the quality of discussion

Areas for improvement:

- Improved data analysis
- Establishing a rhythm for deep dive reports
- Clarity on ICB specific risks with an ICS view

Finance, Performance and Investment Committee

The Finance, Performance and Investment Committee (FPIC) provides assurance and reports directly to the ICB Board to ensure that there are robust and integrated mechanisms in place to ensure detailed review, oversight and assurance of the ICB's financial position and financial strategy. It also provides assurance that all aspects of financial and performance management are operating effectively, through focus upon the key financial and operational performance risk areas across the local system and ensures that the ICB is delivering its required targets.

The duties of the Committee are to:

- To review the financial allocations and budget for the current financial year and make recommendations to the ICB Board for formal authorisation.
- Provide oversight and development of the five-year strategic financial plan for the ICB.
- Review and approve allocation of contingency funding to members of the ICB based against defined metrics. This is to include transformation, productivity and to aid the reduction of health inequalities.
- Approve business cases for strategic investment that are in line with the Scheme of Reservation and Delegation (SORD) and meet the needs of the priorities of the ICB.
- To review and monitor the financial strategy and operational financial plans of the ICB and the current and forecast financial position of the overall ICB budget.
- To review and monitor system wide operational performance in accordance with national operational planning guidance and advise on risks and mitigations.
- Consider and review ongoing financial reports and the Annual Statement to be presented to the ICB Board, incorporating financial performance against budget, targets, financial risk analysis, forecasts and statements on the rigor of underlying assumptions to ensure statutory financial duties are met;
- Providing assurance to the ICB Board about delivery and sustained performance of contracts held by the ICB.
- Where required, the Committee will consider and review any external financial monitoring returns and commentary.

- To receive reports from its sub-committees and groups on their work, and the decisions made.
- To ensure there is development of policies that sit under the remit of the Chief Finance and Performance Officer.
- To approve policies that sit under the remit of the Chief Finance and Performance Officer.
- The Committee will work across the provider collaboratives and place-based partnerships in accordance with the NEL ICS Oversight and Assurance Framework to ensure a proportionate and risk-based approach to performance oversight.
- The Committee will also be updated on progress of the ICB and of Trusts in accordance with the NHS System Oversight Framework (SOF).
- The Committee will oversee the annual operational planning process for activity and performance ensuring alignment to workforce and financial planning processes.

The membership and attendance record of the FPIC is outlined in the table below:

| Name of Committee member | 31 Oct 2022 | 6 Jan 2023 | 27 Feb 2023 | 27 Mar 2023 | Total attended /total possible |
|--|-------------|------------|-------------|-------------|--------------------------------|
| Kash Pandya, Associate Non-Executive Member (Chair) | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Henry Black, Chief Finance and Performance Officer | ✓ | x | ✓ | ✓ | 3/4 |
| Cha Patel, Non-Executive Member | N/A | ✓ | ✓ | ✓ | 3/3 |
| Fiona Smith, Associate Non-Executive Member | ✓ | ✓ | x | ✓ | 3/4 |
| Dr Mark Ricketts, Primary Care Partner Member | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Mayor Philip Glanville, Local Authority Partner Member | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Mohit Venkataram, NHS Trust Partner Member | N/A | ✓ | ✓ | ✓ | 3/3 |

Cha Patel and Mohit Venkataram joined the Committee in January 2023 and were not members for the initial meeting in October 2022.

The meeting is regularly attended by:

- Steve Collins, Executive Director of Finance, NHS North East London

- Rob Adcock, Deputy Chief Finance Officer, NHS North East London
- Clive Walsh, Interim Director of Performance, NHS North East London

The following key topics were discussed by the Committee in 2022/23:

- Monthly finance overviews and reports
- Financial risk overview
- Monthly performance reports
- ICB Operating Plan, budgets and financial strategy/management
- Business cases
- Finance and Performance organisational policies and standard operating procedures
- Capital investments
- The NHS System Oversight Framework
- Oversight of the transfer of delegated responsibility for commissioning of Pharmacy, Optometry and Dental services from NHS England to London ICBs hosted by NEL ICS
- A Joint Working Agreement for Specialised Commissioning
- Primary Care Rebate Schemes
- Covid-19 restoration and recovery
- QIPP delivery
- Winter pressures
- Acute and non-acute contracts
- Developing ICS financial management and reporting

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Active participation from all members
- Positive discussions about critical and sensitive issues
- Good level of debate and challenge

Areas for improvement:

- Complexity of report content
- Performance data presentation
- Increasing the number of deep dives

The Primary Care Contracts Sub-committee is a sub-committee of the Finance, Performance and Investment Committee, the details of which are outlined below.

Primary Care Contracts Sub-committee

The Primary Care Contracts Sub-committee provides oversight of the ICB's primary care contracting functions and to make decisions on the review and procurement of primary care services in North East London and other direct commissioning under delegated authority from NHS England. The role of the sub-committee is to carry out the functions relating to the commissioning and management of primary medical care services in accordance with the agreement entered into between NHS England and the ICB.

The duties of the Sub-committee are to:

- Overseeing arrangements for ensuring effective primary medical services contract management.
- Overseeing the design and commissioning of any enhanced services.
- Overseeing the design and offer local incentive schemes as an alternative to the Quality Outcomes Framework (QOF) or enhanced services.
- Overseeing the development of commissioning proposals for urgent care for out of area registered patients, ensuring compliance with any mandated guidance in relation to:
 - Establishing new primary medical services providers.
 - Approving practice mergers and closures.
 - Dispersing patient lists.
 - Agreeing boundary variations.
- The procurement/award of new contracts (subject to financial limits).
- Overseeing arrangements for commissioning PCN Contract Direct Enhanced Services.
- Overseeing arrangements for commissioning ancillary support services.
- Overseeing arrangements or managing primary medical services providers providing inadequate standards of care.
- Making decisions on discretionary payments and discretionary support.

The membership and attendance record of the Sub-committee is outlined in the table below.

| Name of Committee member | 28 Nov 2022 | 30 Jan 2023 | 22 March 2023 | Total attended /total possible |
|--|-------------|-------------|---------------|--------------------------------|
| Steve Collins, Executive Director of Finance, NHS North East London (Chair) | ✓ | ✓ | ✓ | 3/3 |
| Dr Paul Gilluley, Chief Medical Officer, NHS North East London | X | ✓ | X | 1/3 |
| Diane Jones, Chief Nursing Officer, NHS North East London | ✓ | ✓ | ✓ | 3/3 |
| Johanna Moss, Chief Strategy and Transformation Officer, NHS North East London | ✓ | X | ✓ | 2/3 |
| Mike Fitchett, Independent GP* | X | NA | NA | 0/1 |
| Azeem Nizamuddin, Independent GP* | ✓ | NA | NA | 1/1 |

*Independent GPs were in post until December 2022

The meeting is regularly attended by:

- Sarah See – Managing Director of Primary Care, NHS North East London
- Greg Cairns - Director of Primary Care London-Wide LMCs
- Jane Lindo – Director of Primary Care, NHS North East London
- William Cunningham-Davis – Director of Primary Care, NHS North East London
- Richard Bull – Director of Primary Care, NHS North East London
- Alison Goodlad – Deputy Director of Primary Care, NHS North East London
- Lorna Hutchinson – Assistant Head of Primary Care, NHS North East London
- Gohar Choudary – Assistant Head of Primary Care, NHS North East London
- Madhu Pathak – Barking, Dagenham and Havering LMC
- Rob Dickenson – Senior Finance Manager, NHS North East London

The following key topics were discussed by the Sub-committee in 2022/23:

- Alternative Provider Medical Services (APMS)
- Local Incentive Scheme (LIS)
- Contractual actions and changes
- Risk Register
- Finance Reports
- Remedial Notice

- Deep dive reports
- Acute and non-acute contracts
- Developing ICS financial management and reporting

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Good chair with good knowledge of primary care
- Well organised and timely short papers

Areas for improvement:

- Gaps in understanding of primary care contracting knowledge
- Limited understanding of the regulations that govern the decisions
- Enablement of local decision making.

Population Health and Integration Committee

The purpose of the Committee is to contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the Board on how improved population health and integrated health and care, resulting in improved access, experience and outcomes for local people are being delivered including by the seven place-based partnerships and provider collaboratives and their ICB sub-committees.

The duties of the Committee are:

- To understand the population's needs and assets and have a broad overview of the populations and communities of north east London
- To shape and have oversight of the Improving the Health of All Populations Strategy, or equivalent, as a framework for the development and implementation of effective population health improvement across north east London
- To shape and have oversight of the Working with People and Communities Strategy as a framework for the development and implementation of effective resident participation across north east London
- To review the matrix system of integration and integrated working through the ICB's seven place partnerships and provider collaboratives to ensure that the arrangements are delivering improved access, experience and outcomes in line with the ICB's objectives, priorities and legal duties.
- To seek reports and assurance from place and collaborative leaders as appropriate, with a consistent focus on population health and integration, together with indicators of their effectiveness.
- To identify opportunities to support and improve effective population health management and integration of health and care services at place and within collaboratives.

The membership and attendance record of the Committee is outlined in the table below.

| Population Health and Integration Committee member | 26 Oct 2022 | 13 Dec 2022 | 22 Feb 2023 | Total attended /total possible |
|--|-------------|-------------|-------------|--------------------------------|
| Marie Gabriel CBE (Chair), ICB Chair | ✓ | ✓ | ✓ | 3/3 |
| Zina Etheridge, Chief Executive Officer | ✓ | ✓ | ✓ | 3/3 |
| Louise Ashley, NHS Trust Partner Member | x | ✓ | ✓ | 2/3 |
| Noah Curthoys, Associate Non-executive Member | ✓ | ✓ | ✓ | 3/3 |
| Dr Paul Gilluley, Chief Medical Officer | x | ✓ | ✓ | 2/3 |
| Dr Jagan John, Primary Care Partner Member | ✓ | x | ✓ | 2/3 |
| Councillor Maureen Worby, Local Authority Partner Member | ✓ | ✓ | ✓ | 3/3 |
| Charlotte Pomery, Chief Participation and Place Officer | ✓ | ✓ | ✓ | 3/3 |
| Imelda Redmond CBE, Non-executive Member | ✓ | ✓ | ✓ | 3/3 |
| Fiona Smith, Associate Non-executive Member | ✓ | ✓ | ✓ | 3/3 |

The meeting is regularly attended by:

- Johanna Moss, Chief Strategy and Transformation Officer
- Adrian Loades, executive place-based partnership representative
- Andrew Blake-Herbert, executive place-based partnership representative
- Colin Ansell, executive place-based partnership representative
- Fiona Taylor, executive place-based partnership representative
- Heather Finders, executive place-based partnership representative
- Will Tuckley, executive place-based partnership representative (until 2 March 2023)
- Jacqui Van Rossum, executive provider collaborative representative
- Paul Calaminus, executive provider collaborative representative
- Ralph Coulbeck, executive provider collaborative representative

The following key topics were discussed by the Committee in 2022/23:

- Population health profile for the North East London Health and Care Partnership
- Working with people and communities strategy
- The development of place partnerships and provider collaboratives in north east London
- Integrated care strategy
- Health inequalities funding proposal
- The Big Conversation programme of events

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- The focus across collaboratives, place and systems with the real opportunity to influence decisions
- Proactively seeking to make sense of areas of delegated responsibility
- Building working relationships across the partnership

Areas for improvement:

- Understanding how the items for discussion relate to the flagship priorities and how they interface with other committees.
- Avoiding duplication with health inequalities and population health reports.

The subcommittees of the Population Health and Integration Committee are detailed in the below.

Place-based Integrated Care Board Sub-Committees

The seven Place-based Sub-Committees enable the ICB to exercise delegated functions at Place in a lawful, simple and efficient way, to the extent permitted by the ICB's Constitution and as part of the wider collaborative arrangements which form the Place-based Partnerships. The Sub Committees also support the development of collaborative arrangements at Place, in particular the development of the Place Based Partnership (PBP) and Plan. It also helps support the wider ICB to achieve its agreed deliverables, and to achieve the aims and the ambitions set out in the plans that it enters into and supports, including but not limited to the joint forward plan, the Integrated Care Strategy and joint local health and wellbeing strategies. The Sub Committees report in to, and provide assurance to the Population Health and Integration Committee (PHIC).

The duties of the Sub-committees are to:

- Exercise delegated decision making with particular regard to the objectives and priorities described in the PBP Plan.

- Support the wider ICB to achieve its agreed deliverables, and to achieve the aims and the ambitions of the Joint Forward Plan, the Joint Capital Resource Use Plan, the Integrated Care Strategy, joint local health and wellbeing strategies and joint strategic needs assessment, the Place Mutual Accountability Framework and the NHS North East London Financial Strategy and developing ICS Financial Framework.
- Support the ICS with the achievement of the ‘four core purposes’ of Integrated Care Systems - improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money and help the NHS support broader social and economic development
- Work with the Health and Care Board on behalf of the ICB, to develop a PBP Plan including Place objectives and priorities and a Place outcomes framework.
- Undertake specific activities in relation to:
 - Health and care needs planning, through embedding population health management;
 - Market management, planning and delivery;
 - Local service quality management;
 - Communications and engagement.
- Discharge delegated financial management and control, as detailed within the ICB’s Standing Financial Instructions (SFIs).
- Develop arrangements for integrated services, including primary care, through local neighbourhoods.
- Prepare or contribute to an emergency response plan for implementation at Place, coordinating with local partners as necessary if requested.

Barking and Dagenham Integrated Care Board Sub Committee

The membership and attendance record of the Barking and Dagenham Sub-committee is outlined in the table below.

| Name of Committee member | 29 Sep. 2022 | 26 Jan. 2023 | 30 Mar. 2023 | Total attended /total possible |
|--|---------------------|---------------------|---------------------|---------------------------------------|
| Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health Integration - Co-Chair | ✓ | ✓ | ✓ | 3/3 |
| Ann Hepworth, Director of Strategy & Partnerships, BHRUT | ✓ | X | ✓ | 2/3 |
| Dr Rami Hara, Clinical Care Director, NHS North East London | ✓ | ✓ | ✓ | 3/3 |

| | | | | |
|--|---|---|---|-----|
| Dr Shanika Sharma, Primary Care Network Director – Co-Chair | ✓ | X | ✓ | 2/3 |
| Fiona Taylor, Place Partnership Lead, London Borough of Barking and Dagenham | ✓ | ✓ | X | 2/3 |
| Elaine Allegretti, Strategic Director Children and Adults, LBBD | ✓ | X | X | 1/3 |
| Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham | ✓ | ✓ | ✓ | 3/3 |
| Elsbeth Paisley, Health Lead, BD Collective | ✓ | ✓ | ✓ | 3/3 |
| Selina Douglas, Director of Partnerships, NELFT | x | ✓ | X | 1/3 |
| Manisha Modhvadia, Manager, Healthwatch | x | ✓ | X | 1/3 |
| Sharon Morrow, Place Director, NHS North East London | ✓ | X | X | 1/3 |
| Sunil Thakker, Director of Finance, NHS North East London | x | ✓ | X | 1/3 |
| Mark Gilbey-Cross, Director of Nursing/ Quality, NHS North East London | ✓ | X | X | 1/3 |

NB capacity issues being explored where ICB team colleagues are members across a range of places

The meeting is also attended regularly by the members of the wider Health and Care Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Committed members wanting to make a change
- Representation from health and social care to enable wider discussion.
- Ability to hold meetings in person

Areas for improvement:

- Discussion can feel clinically-led
- Heavy agendas can lead to limited discussion time to work through complex issues

City and Hackney Integrated Care Board Sub Committee

The membership and attendance record of the City and Hackney Integrated Care Board Sub Committee is outlined in the table below.

| Name of Committee member | 8 Sep 2022 | 10 Nov 2022 | 9 Mar 2023 | Total attended /total possible |
|---|------------|-------------|------------|--------------------------------|
| Nina Griffith, Delivery Director for City & Hackney, NHS North East London | X | ✓ | X | 1/3 |
| Dr Steph Coughlin, Clinical Care Director for City & Hackney, NHS North East London | ✓ | ✓ | ✓ | 3/3 |
| Sunil Thakker, Director of Finance, NHS North East London | X | ✓ | ✓ | 2/3 |
| Mark Gilbey-Cross, Director of Nursing/Quality, NHS North East London | ✓ | ✓ | X | 2/3 |
| Helen Woodland, Group Director for Adults, Health and Integration, London Borough of Hackney | ✓ | ✓ | ✓ | 3/3 |
| Jacque Burke, Group Director for Children and Education, London Borough of Hackney | ✓ | ✓ | X | 2/3 |
| Simon Cribbens, Director of Community and Children's Services, City of London Corporation | ✓ | ✓ | ✓ | 3/3 |
| Dr Sandra Husbands, Director of Public Health for City & Hackney, London Borough of Hackney | X | ✓ | ✓ | 2/3 |
| Councillor Chris Kennedy, Local Authority Elected Member, London Borough of Hackney | ✓ | ✓ | ✓ | 3/3 |
| Helen Fentimen, Local Authority Elected Member, City of London Corporation (Chair) | ✓ | ✓ | ✓ | 3/3 |
| Louise Ashley, Chief Executive & Place Partnership Lead, Homerton Healthcare NHS Foundation Trust | X | ✓ | ✓ | 2/3 |
| Paul Calaminus, Director of ELFT, East London NHS Foundation Trust | X | X | ✓ | 1/3 |
| Dr Tehseen Khan, Joint Primary Care Network Clinical Director | X | x | X | 0/3 |
| Dr Jenny Darkwah, Joint Primary Care Network Clinical Director | X | x | X | 0/3 |

| | | | | |
|--|---|---|---|-----|
| Dr Kirsten Brown, Place-Based Partnership Primary Care Development Clinical Lead | ✓ | ✓ | ✓ | 3/3 |
| Tony Wong, Chief Executive Officer, Hackney Council for Voluntary Service | ✓ | ✓ | ✓ | 3/3 |

The meeting is also attended regularly by the members of the wider Health and Care Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Sub-committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Well attended meetings which enable effective discussion
- High quality written reports

Areas for improvement:

- More alignment with Health and Wellbeing Boards could be beneficial
- Greater authority to take decisions following the approval of the Mutual Accountability Framework

Havering Integrated Care Board Sub Committee

The membership and attendance record of the Havering Sub-committee is outlined in the table below.

| Name of Committee member | 14 Sep. 2022 | 9 Nov. 2022 | 11 Jan. 2023 | 8 Mar. 2023 | Total attended /total possible |
|---|--------------|-------------|--------------|-------------|--------------------------------|
| Dr Narinderjit Kullar, Clinical Care Director, NHS North East London | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Cllr Gillian Ford, Councillor, Lead Member for Adult Social Care and Health, London Borough of Havering (Chair) | ✓ | ✓ | ✓ | ✓ | 4/4 |

| | | | | | |
|---|---|---|---|---|-----|
| Dr Jwala Gupta, primary care sector Partnership Board member - Co-Chair | ✓ | ✓ | ✓ | X | 3/4 |
| Brid Johnson, Interim Executive Integrated Care Director, NELFT | ✓ | x | ✓ | ✓ | 3/4 |
| Barbara Nicholls, Director of Adult Social Care, London Borough of Havering | ✓ | ✓ | X | ✓ | 3/4 |
| Ann Hepworth, Director of Strategy and Partnerships, BHRUT | X | x | ✓ | ✓ | 2/4 |
| Mark Ansell, Director of Public Health, London Borough of Havering | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Andrew Blake-Herbert, Chief Executive of London Borough of Havering, Place Partnership Lead and Chair | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Ben Molyneux, Primary Care Development Clinical Lead | x | x | X | X | 0/4 |
| Robert South, Director of Children's Services, London Borough of Havering | x | ✓ | X | X | 1/4 |
| Luke Burton, Delivery Director, NHS North East London | ✓ | ✓ | ✓ | ✓ | 4/4 |
| Sunil Thakker, Director of Finance, NHS North East London | x | ✓ | x | ✓ | 2/4 |
| Mark Gilbey Cross/ Chetan Vyas, Director of Nursing/Quality, NHS North East London | ✓ | x | x | X | 1/4 |

The meeting is also attended regularly by the members of the wider Health and Care Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- The commitment and willingness to work as a partnership
- Local residents are at the heart of discussions
- Strengthened relationships between partner organisations

Areas for improvement:

- Improving connections with provider collaboratives
- Increasing focus on children's health, care and wellbeing
- Lengthy agendas can lead to limited discussions

Newham Integrated Care Board Sub Committee

The membership and attendance record of the Newham Sub-committee is outlined in the table below.

| Name of Committee member | 30 Sep. 2022 | 25 Nov. 2023 | 31 Mar. 2023 | Total attended / total possible |
|--|-----------------|-----------------|-----------------|---------------------------------|
| Colin Ansell, Chief Executive/Place Partnership Lead, London Borough of Newham (Chair) | ✓ | ✓ | ✓ | 3/3 |
| Rima Vaid, Clinical Care Director, NHS North East London | ✓ | ✓ | ✓ | 3/3 |
| John Rooke, Director of Delivery, NHS North East London (until November 2022) | ✓ | N/A | N/A | 1/1 |
| Jo Frazer-Wise/ Marie Trueman-Able, Director of Delivery (Interim/job share), NHS North East London (from November 2022) | N/A | ✓ | ✓ | 2/2 |
| Karen Livingstone, Chief Executive Officer, Newham Health Collaborative | ✓ | ✓ | ✓ | 3/3 |
| Tim Aldridge, Director of Children's Services, London Borough of Newham | ✓ | ✓ | X | 2/3 |
| Nadeem Faruq, Chair, Newham Health Collaborative | ✓ | ✓ | X | 2/3 |
| Sunil Thakker, Director of Finance, NHS North East London | ✓ | ✓ | X | 2/3 |
| Richard Fradgley, Director of Integrated Care & Deputy Chief Executive Officer, East London Foundation Trust | ✓ | ✓ | ✓ | 3/3 |
| Simon Ashton, Chief Executive Officer, Newham University Hospital | ✓ | ✓ | ✓ | 3/3 |

| | | | | |
|---|---|---|---|-----|
| Muhammad Nagvi, Primary Care Development Clinical Lead, NHS North East London | ✓ | ✓ | ✓ | 3/3 |
| Jason Strelitz, Director of Adult Social Care and Public Health, London Borough of Newham | ✓ | ✓ | ✓ | 3/3 |
| Julie Pal/ Veronica Awizudike, Healthwatch Newham | ✓ | ✓ | ✓ | 3/3 |
| Mark Gilbey-Cross/ Chetan Vyas, Director of Nursing/ Quality, NHS North East London | x | ✓ | X | 1/3 |

The meeting is also attended regularly by the members of the wider Health and Care Partnership Board and colleagues to support and provide expert guidance and advice. The following key topics were discussed by the Committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Participation is rich and colleagues are fully engaged
- Strong sense of partnership

Areas for improvement:

- Having a clear forward plan for the sub-committee
- Hybrid technology to enable face-to-face and virtual attendance

Redbridge Integrated Care Board Sub Committee

The membership and attendance record of the Redbridge Sub-Committee is outlined in the table below.

| Name of Committee member | 15 Sept 2022 | 16 March 2023 | Total attended /total possible |
|--|-----------------|------------------|--------------------------------|
| Adrian Loades, Place Partnership Lead, London Borough of Redbridge (Chair) | ✓ | x | 1/2 |
| Tracy Rubery, Delivery Director for Redbridge, NHS North East London | ✓ | ✓ | 2/2 |
| Dr Anil Mehta, Clinical Care Director for Redbridge, NHS North East London | ✓ | ✓ | 2/2 |
| Sunil Thakker, Director of Finance, NHS North East London | x | ✓ | 1/2 |
| Mark Gilbey-Cross/ Chetan Vyas, Director of Nursing/Quality, NHS North East London | x | x | 0/2 |
| Gladys Xavier, Director of Public Health, London Borough of Redbridge | ✓ | ✓ | 2/2 |
| Councillor Mark Santos, Cabinet Member for Adult Social Care and Health, London Borough of Redbridge | ✓ | x | 1/2 |
| Bob Edwards, Director of NELFT, North East London NHS Foundation Trust | X | ✓ | 1/2 |
| Ann Hepworth, Director of BHRUT, Barking, Havering & Redbridge NHS Trust | X | X | 0/2 |
| Dr Amanjit Jhund, Barts Health NHS Trust | x | x | 0/2 |
| Jyoti Sood, Joint Place Based Partnership Primary Care Development Clinical Lead | N/A | ✓ | 1/1 |
| Joint Primary Care Representative (rotating between Drs Ramakrishnan, Ali, Hameed, Umrani, Tahir, Bhatti, Pazhanisami, Dhillon and Clarke) | ✓ | ✓ | 2/2 |
| Jenny Ellis, Redbridge CVS Representative | ✓ | ✓ | 2/2 |
| Cathy Turland, Healthwatch Redbridge Representative | x | ✓ | 1/2 |

The meeting is also attended regularly by the members of the wider Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Sub-committee in 2022/23:

- The Terms of Reference

- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Partners are considering the interfaces between agencies and what can be collectively achieved
- Strong leadership and commitment to partnership working

Areas for improvement:

- Lack of resources and infrastructure to enable meaningful and equitable voluntary sector participation,
- Meetings held entirely online affected ability to build trusting relationships

Tower Hamlets Integrated Care Board Sub Committee

The membership and attendance record of the Tower Hamlets Sub-committee is outlined in the table below.

| Name of Committee member | 1 Sept 2023 | 2 March 2023 | Total attended /total possible |
|--|-------------|--------------|--------------------------------|
| Amy Gibbs, Independent Chair | ✓ | ✓ | 2/2 |
| Warwick Tomsett, Director of Integrated Commissioning, NHS North East London & London Borough of Tower Hamlets | ✓ | ✓ | 2/2 |
| Roberto Tamsanguan, Clinical Care Director for Tower Hamlets, NHS North East London | ✓ | ✓ | 2/2 |
| Sunil Thakker, Director of Finance, NHS North East London | ✓ | x | 1/2 |
| Mark Gilbey-Cross, Director of Nursing/Quality, NHS North East London | ✓ | x | 1/2 |
| Denise Radley, Corporate Director Health, Adults & Community, London Borough of Tower Hamlets | ✓ | x | 1/2 |

| | | | |
|---|-----|------|-----|
| James Thomas, Corporate Director of Children and Culture, London Borough of Tower Hamlets | ✓ | ✓ | 2/2 |
| Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets | x | ✓ | 1/2 |
| Neil Ashman, Chief Executive Officer, Royal London and Mile End Hospitals, Barts Health NHS Trust | ✓ | x | 1/2 |
| Richard Fradgley, Director of Integrated Care, East London NHS Foundation Trust | ✓ | ✓ | 2/2 |
| Chris Banks, Joint Chief Executive, GP Care Group | ✓ | ✓ | 2/2 |
| Zainab Arian, Joint Chief Executive, GP Care Group | N/A | ✓ | 1/1 |
| Peter Okali, Chief Executive Officer, Tower Hamlets CVS | ✓ | /N/A | 1/1 |
| Vicky Scott, Chief Executive Officer, Tower Hamlets CVS | N/A | ✓ | 1/1 |
| Matthew Adrien, Representative, Healthwatch | ✓ | ✓ | 2/2 |
| Khyati Bakhai, Place Based Partnership Primary Care Development Clinical Lead | N/A | ✓ | 1/1 |
| Julia Slay, Resident and community representative | ✓ | N/A | 1/1 |
| Muna Hassan, Resident and community representative | N/A | ✓ | 1/1 |

The meeting is also attended regularly by the members of the wider Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Sub-committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Members were engaged and worked in an integrated way
- Strong resident voice

Areas for improvement:

- Prioritising system issues
- Finance reports could be clearer

Waltham Forest Integrated Care Board Sub Committee

The membership and attendance record of Waltham Forest Sub-Committee is outlined in the table below:

| Name of Committee member | 5 September 2022 | 9 January 2023 | 6 March 2023 | Total attended /total possible |
|--|------------------|----------------|--------------|--------------------------------|
| Ken Aswani, Clinical Care Director for Waltham Forest, NHS North East London | ✓ | ✓ | ✓ | 3/3 |
| Sue Boon, Delivery Director for Waltham Forest, NHS North East London & North East London NHS Foundation Trust | ✓ | x | ✓ | 2/3 |
| Mark Lobban, Director of Integrated Commissioning NHS North East London & London Borough of Waltham Forest | x | N/A | N/A | 0/1 |
| Sunil Thakker, Director of Finance, NHS North East London | x | x | ✓ | 1/3 |
| Mark Gilbey-Cross, Director of Nursing/Quality, NHS North East London | x | x | x | 0/3 |
| Heather Flinders, Strategic Director of People (Co-Chair), London Borough of Waltham Forest | x | ✓ | ✓ | 2/3 |
| Joe McDonnell, Director of Public Health, London Borough of Waltham Forest | x | X | ✓ | 1/3 |
| Daniel Phelps, Corporate Director Children's Social Care, London Borough of Waltham Forest | ✓ | ✓ | ✓ | 3/3 |
| Darren McAughtrie, Director Adult Care and Quality Standards, London Borough of Waltham Forest | ✓ | x | ✓ | 2/3 |
| Ralph Coulbeck, Chief Executive, Whipps Cross Hospital (Co-Chair), Barts Health NHS Trust | ✓ | ✓ | ✓ | 3/3 |

| | | | | |
|---|---|---|---|-----|
| Oluremi Odejinmi, Medical Director, Whipps Cross Hospital, Barts Health NHS Trust | x | ✓ | x | 1/3 |
| Selina Douglas, Executive Director Strategy, North East London NHS Foundation Trust | x | ✓ | ✓ | 2/3 |
| Dr Naheed Khanlodhi, Primary Care Network Primary Care Representative | ✓ | ✓ | x | 2/3 |
| Dr Janakan Crofton, Place Based Partnership Primary Care Development Clinical Lead | ✓ | x | x | 1/3 |
| Vanessa Morris, Chief Executive, Waltham Forest Healthwatch | ✓ | ✓ | ✓ | 3/3 |
| Dianne Barham, Representative, Community and Voluntary Sector | ✓ | ✓ | x | 2/3 |

The meeting is also attended regularly by the members of the wider Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Sub-committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Effective forward planning
- Strong senior leadership

Areas for improvement:

- Resident participation to be further developed
- Local priorities conflicting with ICS system demand.

Mental Health, Learning Disability and Autism Collaborative Sub Committee

The Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative Sub-committee has been established with a view to enabling the NHS Partner Organisations to work collaboratively, with a shared purpose and at scale across multiple places in north east London, to improve outcomes, quality, value and equity for residents of north east London with, or at risk of, MHLDA. The duties of the Committee/ Sub-committee are to:

- Provide the NHS Partner Organisations with the ability to collaboratively direct and oversee the delivery of high-quality patient care relating to in-scope MHLDA services in North East London;
- Support the development of further collaboration between the NHS Partner Organisations (including working together towards the Sub-Committee receiving a formal delegation for the functions associated with the Mental Health Investment Standard and other investment into mental health, and exploring opportunities for formal joint working).
- Enable collaboration with an emphasis on minimising health inequalities, striving to: embed joint accountability, improve equity of access to appropriate and timely health services, and to ensure the needs and experiences of communities can be considered over whole pathways of care;
- Ensure and encourage the engagement of all the partner organisations of the ICS, with a view to shaping the future of MHLDA services across North East London;
- Coordinate work to reduce inequalities in health outcomes, access and experience where it is the case that action across the NHS Partner Organisations and/or the ICS is required;
- Coordinate improved resilience of services (e.g. by mutual aid) where it is the case that action across the NHS Partner Organisations and/or the ICS is required and ensure that specialisation and consolidation can occur where this will provide better outcomes and value;
- Ensure that people participation is at the heart of all the activities of the Sub-Committee, and of the collaborative's wider work;
- Leading the development of the ICS strategy for MHLDA, and put in place arrangements to ensure its delivery with ICS partners including the seven place-based partnerships;
- Provide assurance to the ICB on the delivery of the ICS strategy for MHLDA, including service user and carer led priorities, and the NHS Long Term Plan; and agree mitigations where there are significant delivery risks;
- Lead annual planning to meet the needs of people for MHLDA services in North East London across the ICS;

The membership and attendance record of the Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative Sub-committee is outlined in the table below.

| Name of Committee member | 23 Nov 2022 | 25 Jan 2023 | 22 Mar 2023 | Total attended /total possible |
|---|-------------|-------------|-------------|--------------------------------|
| Eileen Taylor, Chair (from January 2023) and Joint Chair of ELFT and NELFT | ✓ | ✓ | ✓ | 3/3 |
| Marie Gabriel CBE, Chair of NHS North East London and North East London Health & Care Partnership (Interim sub-committee Chair) | ✓ | N/A | N/A | 1/1 |
| Zina Etheridge, Chief Executive Officer, NHS North East London | ✓ | ✓ | ✓ | 3/3 |
| Henry Black, Chief Finance and Performance Officer, NHS North East London | ✓ | ✓ | X | 2/3 |
| Professor Dame Donna Kinnair, Non-Executive Director, ELFT | ✓ | X | X | 1/3 |
| Paul Calaminus, Chief Executive Officer, ELFT | ✓ | ✓ | ✓ | 3/3 |
| Selina Douglas, Executive Director of Partnerships, NELFT | ✓ | ✓ | ✓ | 3/3 |
| Richard Fradgley, Executive Director of Integrated Care - ELFT | ✓ | ✓ | ✓ | 3/3 |
| Dr Mohit Venkataram, Lead Director for New Models of Care, ELFT | ✓ | ✓ | X | 2/3 |
| Jacqui Van Rossum, Acting Chief Executive Officer, NELFT | X | X | X | 0/3 |

| | | | | |
|--|---|---|---|-----|
| Sultan Taylor, non-executive Director, NELFT | ✓ | ✓ | ✓ | 3/3 |
| Johanna Moss, Chief Strategy and Transformation officer, NHS North East London | X | ✓ | ✓ | 2/3 |

The meeting is also attended regularly by:

- Participant observers from ELFT, NELFT, Healthwatch and the voluntary sector
- Brid Johnson, Acting Executive Director of Integrated Care, NELFT
- Sue Boon, Director of Delivery Waltham Forest, NELFT and NHS North East London
- Wellington Makala, Executive Chief Nursing Officer/ Executive Director AHP & Psychological Professions, North East London NHS Foundation Trust
- Carys Esseen, Deputy Director of Integrated Care, East London NHS Foundation Trust

The following key topics were discussed by the sub-committee in 2022/23:

- Outputs from the Mental Health Summit 2022 and NEL ICS Mental Health Strategy Workshop
- Draft ICS Mental Health Strategy
- Operational planning 2023-2024/5
- Mobilising the MHLDA diagnostic
- Urgent and emergency care
- NEL Lived Experience Leadership proposal
- Mental health joint forward plan
- Perinatal Provider Collaborative development
- Learning disability & autism final plan
- Mental Health final plan

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- The meetings and discussions were service user driven

Areas for improvement:

- Scheduling around all members' commitments was difficult and often led to some apologies which may have lessened discussions.

Primary Care Collaborative Sub-Committee

The North East London Primary Care Collaborative Sub-Committee has been established by the Population Health and Integration Committee to enable primary care leaders from general practice, pharmacy, dentistry and optometry to work collaboratively, with a shared purpose, and at scale across north east London. As 2022/2023 is a transitional year, the sub-committee focussed on determining the vision and arrangements for future collaboration.

The duties of the sub-committee are to:

- Agree the clinical consensus for primary care services strategy and transformation programmes at scale across north east London;
- Work to reduce inequalities in care provision and unwarranted variation in outcomes for patients and residents;
- Act as a forum for learning and sharing best practice based on robust data;
- Provide a forum for other provider collaborative groups to engage with primary care services across the ICS;
- Support work occurring across and within the place-based partnerships to improve population health and healthcare;
- Ensure primary care services are delivering and are focused on continuous quality improvement.
- Support the ICB to achieve the aims and ambitions of the joint forward plan, joint capital resource use plan, the integrated care strategy and where applicable the joint health and wellbeing strategies and plans prepared by the seven place based partnerships.

The membership and attendance record of the Primary Care Collaborative Sub-Committee is outlined in the table below.

| Member | 18Jan 2023 | 8 Mar 2023 | Total attended /total possible |
|---|------------|------------|--------------------------------|
| Johanna Moss, Chief Strategy & Transformation Officer, NHS NEL | ✓ | ✓ | 2/2 |
| Sarah See, Managing Director of Primary Care, NHS NEL | ✓ | ✓ | 2/2 |
| Dr Mark Rickets, Primary care partner member (Co-Chair) | N/A | ✓ | 1/1 |
| Dr Jagan John, Primary care partner member (Co-Chair) | N/A | ✓ | 1/1 |
| Henry Black, Chief Finance and Performance Officer, NHS North East London | X | X | 0/2 |

| Member | 18 Jan 2023 | 8 Mar 2023 | Total attended /total possible |
|---|-------------|------------|--------------------------------|
| Mark Gilbey-Cross, Director of Nursing, NHS North East London | ✓ | ✓ | 2/2 |
| Dr Mohammed Naqvi, General practice provider | ✓ | ✓ | 2/2 |
| Dr Sanjoy Kumar, General practice provider | ✓ | ✓ | 2/2 |
| Yogendra Parmar, Pharmacy provider | ✓ | ✓ | 2/2 |
| Shilpa Shah, Pharmacy provider group rep | ✓ | ✓ | 2/2 |

Representation from optometry and dentistry provider groups will be members of this collaborative in 2023/24.

The meeting is also attended regularly by:

- Dr Kanika Rai, Place based clinical lead
- Dr Kirsten Brown, Place based clinical lead
- Dr Ben Molyneux, Place based clinical lead
- Dr Khyati Bakhai, Place based clinical lead
- Dr Janakan Crofton, Place based clinical lead

The following key topics were discussed by the sub-committee in 2022/23:

- strategic context and how the collaborative will operate;
- terms of reference;
- progress on the establishment of the provider group sub groups
- primary care governance review
- its role in the system integration programme.

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Active engagement from members
- Development of effective terms of reference

Areas for improvement:

- Inclusion of wider primary care partners
- Developing an effective forward plan

Community Health Collaborative Sub-Committee

The North East London Community Health Collaborative Sub-committee has been established with a view to enabling the NHS Partner Organisations to work collaboratively, with a shared purpose, and at scale across multiple places in North East London, to reduce inequalities in health outcomes, improve access and experience; strengthen resilience (e.g. by mutual aid); and ensure that specialisation and consolidation can occur where this will provide better outcomes and value. It has been acknowledged that 2022/2023 is a transitional year and, accordingly, the focus of the Community Health Collaborative will be on determining the vision and arrangements for future collaboration with a view to shaping the future of community services across North East London and enable the joint exercise of Delegated Functions in a simple and efficient way in the future. The Sub Committee reports to, and provides assurance to the Population Health and Integration Committee (PHIC)

The duties of the Sub-committee are to:

- Provide the NHS Partner Organisations with the ability to collaboratively direct and oversee the delivery of high-quality patient care relating to in-scope community health related services in North East London;
- Support the development of further collaboration between the NHS Partner Organisations;
- Enable collaboration with an emphasis on minimising health inequalities, striving to: embed joint accountability, improve equity of access to appropriate and timely health services;
- Ensure and encourage the engagement of all the partner organisations of the ICS, with a view to shaping the future of community services across North East London;
- Enable the joint exercise of any Delegated Functions in a simple and efficient way;
- Making recommendations to the PH&I Committee in relation to, and contributing to, the Joint Forward Plan and Joint Capital Resource Use Plan and other system plans, in so far as it relates to the provision of, and the need for, Community Services in the ICB's area and the exercise of the ICB's functions;
- Developing and approving the North East London Community Services Plan and overseeing implementation and delivery of the initial workplan, in so far as that requires the exercise of ICB functions;
- Holding responsibility on behalf of the ICB for engagement with partner organisations within the ICS (including primary care) on matters relating to the provision of, and the need for, Community Services with a view to ensuring that such needs are considered within wider system planning.

The membership and attendance record of the Community Health Collaborative Sub-committee is outlined in the table below.

| Name of Committee member | 16 Jan 2023 | 20 Mar 2023 | Total attended /total possible |
|--|-------------|-------------|--------------------------------|
| Johanna Moss, Chief Strategy and Transformation Officer, NHS North East London | ✓ | ✓ | 2/2 |
| Charlotte Pomery, Chief Participation and Place Officer, NHS North East London | ✓ | ✓ | 2/2 |
| Mark Turner, Director of Strategy and Integration, Barts Health NHS Trust | ✓ | x | 1/2 |
| Ann Hepworth, Director of Strategy and Partnerships, Barking, Havering & Redbridge NHS Trust | x | ✓ | 1/2 |
| Dylan Jones, Director of Strategic Implementation and Partnerships, Homerton Healthcare NHS Foundation Trust | ✓ | ✓ | 2/2 |
| Richard Fradgley, Director of Integrated Care and Deputy Chief Executive Officer, East London NHS Foundation Trust | ✓ | ✓ | 2/2 |
| Ruth Bradley, Clinical Director (Nursing / AHP or Medical), East London NHS Foundation Trust | x | ✓ | 1/2 |
| Jacqui Van Rossum, Chief Executive, North East London NHS Foundation Trust (Chair) | ✓ | ✓ | 2/2 |
| Selina Douglas, Executive Director of Partnerships, North East London NHS Foundation Trust | ✓ | ✓ | 2/2 |

Some members are still in the process of being selected for membership of the Sub Committee, including from partner NHS Trusts and attendees to provide input from Places and service users or carers. The meeting is also attended regularly by the following colleagues to provide expert advice and support:

- Helen Woodland, Nominated Local Authority representative, London Borough of Hackney
- Mags Farley, Divisional Operations Director for Community and Children's Services, Homerton Healthcare NHS Foundation Trust

The following key topics were discussed by the Committee/ Sub-committee in 2022/23:

- The Terms of Reference

- Community Collaborative Development - Framework for delivery and Programme Structure
- 2023/24 Priorities and Operational Planning Update
- Community reference group proposal
- User of services and carers proposal
- Deep Dives on Virtual Wards and Children and Young People’s Speech and Language Therapies (SALT)

Committee effectiveness review

Comments were received on what had gone well this year and what could be improved.

Things that went well:

- Deep dives into areas including virtual wards and BCYP SALT.
- Proposals to develop a service user and carers voice.
- Good discussion on proposals to improve outcomes and reduce variation.

Areas for improvement:

- Resources to deliver plans

Acute Provider Collaborative

Our acute providers, Barts Health, BHRUT and Homerton Healthcare have been working ever closer over the past year – focussed on reducing elective waits, but also exploring and developing further integrated working arrangements. Work is underway to develop terms of reference for a new Joint Committee of the ICB and acute providers; planned to be established in the first quarter of 2023/24.

Quality, Safety and Improvement Committee

The Quality, Safety and Improvement Committee is a sub-committee of the ICB Board. It provides assurance to the ICB Board that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality, and as enshrined in law by National Health Service Act 2006 (as amended by the Health and Care Act 2022). The Committee exists to scrutinise the robustness of, and gain and provide assurance to the Board that there is an effective system of quality governance and internal control that supports the ICB to effectively deliver its strategic objectives and provide sustainable, high quality care.

The duties of the Committee are to:

- Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern.

- Agree and put forward for Board approval the key quality priorities that are included within the ICB's Joint Forward Plan and the North East London (NEL) Integrated Care Partnership's Integrated Health and Care Strategy and be assured of their delivery. The Committee will contribute to the development of those plans/strategies, as appropriate and relevant to quality matters.
- Be assured of the delivery of the ICB's statutory duties relating to Quality.
- Review and monitor such risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the Board is kept informed of significant risks and mitigation plans, in a timely manner.
- Inform and assure the Committee, that relevant Quality related national and regional guidance/ legislation has been reviewed and relevant actions have been undertaken.
- Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes, across NEL, at Place, within programmes, at Provider Collaboratives, supporting the development of one system approach to quality improvement.
- Receive assurance that the ICB has continuous regard to ensuring and improving its systems and processes to maintain patient safety, including identifying lessons learned from all relevant sources including: incidents; never events; complaints and claims; and ensure that learning is disseminated and embedded across the ICS.
- Receive updates in relation to any investigations relevant to matters in the purview of the Committee.
- Insofar as relates to quality matters, approve and oversee the adaption of legacy policies for use across the ICB until new policies are developed.
- Receive thematic updates regarding learning from Quality matters across NEL i.e. learning from deaths, complaints, serious incidents and PFD reports.
- Be assured that people receiving services are systematically and effectively involved as equal partners in quality activities.
- Approve Terms of Reference and work programmes for, any groups reporting into the Committee.

The membership and attendance record of the Quality, Safety and Improvement Committee is outlined in the table below.

| Name of Committee member | 12 Oct. 2022 | 7 Dec. 2022 | 12 Feb. 2023 | Total attended /total possible |
|--|-----------------|----------------|-----------------|-----------------------------------|
| Imelda Redmond CBE, Non-executive member, NHS North East London - Chair | ✓ | ✓ | ✓ | 3/3 |

| | | | | |
|--|-----|-----|---|-----|
| Marie Gabriel CBE, Non-executive member, NHS North East London | ✓ | ✓ | X | 2/3 |
| Fiona Smith, Associate non-executive member, NHS North East London | ✓ | ✓ | ✓ | 3/3 |
| Dr Jagan John, Primary care partner member | ✓ | ✓ | X | 2/3 |
| Councillor Maureen Worby, Local Authority partner member | ✓ | ✓ | X | 2/3 |
| Mamta Vaidya, NHS Trust partner member | N/A | N/A | X | 0/1 |
| Diane Jones, Chief Nursing Officer, NHS North East London | ✓ | ✓ | ✓ | 3/3 |
| Dr Paul Gilluley, Chief Medical Officer, NHS North East London | ✓ | ✓ | X | 2/3 |
| Charlotte Pomery, Chief Participation and Place Officer, NHS North East London | N/A | ✓ | ✓ | 2/2 |

The meeting is also attended regularly by:

- Chetan Vyas - Director of Quality Development, NHS NEL
- Mark Gilbey-Cross – Director of Nursing, NHS NEL
- Korkor Ceasar - Associate Director, Children's Safeguarding, NHS NEL
- Celia Jeffreys - Associate Director, Safeguarding Adults, NHS NEL
- Moira Coughlan - Deputy Director for Screening, Prevention and Vaccination, NHS NEL
- Philippa Cox - Assistant Director of Maternity Programmes, NHS NEL

The following key topics were discussed by the Committee in 2022/23:

- Terms of Reference.
- Quality Exception Reports
- Local Maternity & Neonatal Services
- Immunisations and Screening
- Urgent Treatment Care Pathways
- Quality at Place
- Strategic risk register

Some of the areas that the committee requested more detailed reports on in the form of 'deep dives' were: Resident Access to Urgent and Emergency Care and CQC Assessment of Integrated Care.

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Willingness from members to learn from feedback
- Good representation from different partners

Areas for improvement:

- Developing a forward plan that adds value and allows a focus on improvement
- Defining the system's key quality issues

Workforce and Remuneration Committee

The Workforce and Remuneration Committee is responsible for shaping and approving the ICB's internal People and Culture Strategy, assuring the implementation of the Integrated Care System People Plan and for overseeing the delivery of the ICS Workforce Strategy. The committee determines all aspects in regard to pay and remuneration for employees of the ICB, in particular very senior staff.

The duties of the Committee are to:

- Determine the ICB's remuneration/pay policy and standard terms and conditions.
- Determine the ICB's pay policy
- Make decisions on the remuneration and conditions of service in regard to ICB board members and very senior managers (VSM) managers.
- Appointment, Appraisal and board succession planning.
- Have responsibility for the workforce priority on behalf of the ICS. This includes creating meaningful employment for the local population across north east London. Creating a 'One NEL' workforce across Health and Social Care which contributes to creating a healthy community and creates a set of working environments in which a diverse and inclusive workforce can work and develop their careers.

The membership and attendance record of the Workforce and Remuneration Committee is outlined in the table below.

| Name of Committee member | 1 July 2022 | 20 July 2022 | 19 Oct 2022 | 5 Dec 2022 | 22 Feb 2023 | Total attended /total possible |
|---|-------------|--------------|-------------|------------|-------------|--------------------------------|
| Diane Herbert, Chair and Non-executive member, North East London ICB | ✓ | X | ✓ | ✓ | ✓ | 4/5 |
| Marie Gabriel CBE, Chair of NHS North East London and North East London Health and Care Partnership | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |

| | | | | | | |
|---|-----|-----|-----|-----|-----|-----|
| Fiona Smith, Associate non-executive member (<i>Member until August 2022</i>) | ✓ | ✓ | N/A | N/A | N/A | 2/2 |
| Sue Evans, Associate non-executive member (<i>from February 2023</i>) | N/A | N/A | N/A | N/A | ✓ | 1/1 |
| Noah Curthoys, Associate non-executive member | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| Dr Mark Rickets, Primary care partner member | N/A | N/A | ✓ | ✓ | X | 2/3 |
| Will Tuckley, Local authority Partner member | N/A | N/A | X | ✓ | X | 1/3 |
| Daniel Waldron, Trust partner member | N/A | N/A | N/A | N/A | ✓ | 1/1 |

The meeting is also attended regularly by:

- Zina Etheridge – Chief Executive Officer, NHS North East London
- Francesca Okosi - Chief People and Culture Officer, NHS North East London
- Jennifer Burton - Interim Head of HR, NHS North East London

The following key topics were discussed by the Committee in 2022/23:

- Development of the ICS workforce strategy
- ICB re-structure
- Speak up Guardian
- Clinical care leader population

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Effective leadership and good Chairing
- Good cross section of expertise and representation of system members

Areas for improvement:

- Increased oversight of the workforce strategy to enable straight forward things
- Reports should be written to a high level with less intricate detail

Non-Executive Member Remuneration Committee

The Non-executive Remuneration Committee has a limited role for the special purpose of:

- considering the remuneration of non-executive members of the ICB and associate non-executive members.

The inaugural meeting of this committee was held on 1 July 2022. A further meeting during 2022/23 has not been required. Since the inaugural meeting on 1 July 2022, the Terms of Reference have been reviewed and the membership has changed and now includes a local authority partner member. The next meeting of the committee with its revised membership is scheduled for July 2023

The membership and attendance record for the meeting held on 1 July 2022 is outlined in the table below.

| Name of Committee member | 1 July 2022 | Total attended /total possible |
|---|-------------|--------------------------------|
| Marie Gabriel CBE, Committee Chair and Chair of NHS North East London and North East London Health and Care Partnership | ✓ | 1/1 |
| Zina Etheridge, Chief Executive, NHS North East London | ✓ | 1/1 |
| Paul Calaminus, Trust partner member | ✓ | 1/1 |
| Shane DeGaris, Trust partner member | ✓ | 1/1 |
| Dr Mark Rickets, Primary care partner member | ✓ | 1/1 |

The meeting is also attended regularly by:

- Francesca Okosi - Chief People and Culture Officer, NHS North East London
- Jennifer Burton - Interim Head of HR, NHS North East London

The following key topics were discussed by the Committee at its meeting on 1 July 2022:

- Remuneration for NHS North East London non-executive members
- Remuneration for NHS North East London associate non-executive members.

North East London Integrated Care Partnership

The North East London Integrated Care Partnership (ICP) is a statutory joint committee that brings together a broad alliance of organisations concerned with improving the care and health and wellbeing of the population of North East London. Alongside the Integrated Care Board, the ICP gives a statutory underpinning to the North East London Health and Care Partnership. Additionally, the ICP has a role in the relation to the Place-Based Partnership arrangements established in the seven places across North East London.

The duties of this joint committee are to:

- Meet the five expectations of integrated care partnerships. It shall:
 - Drive the direction and policies of the ICS;
 - Be rooted in the needs of people, communities and places;
 - Create a space to develop and oversee population health strategies to improve health outcomes and experiences;
 - Support integrated approaches to subsidiarity;
 - Take an open and inclusive approach to strategy development and leadership, involving communities and partners, and utilising local data and insights.
- Develop an integrated care strategy which sets out how assessed needs in relation to its area are to be met by the exercise of functions of the ICB, NHS England and/or the eight local authority partner organisations.
- Have a lead role in co-ordinating partners to develop the Strategic Priorities of the ICS.
- Make recommendations to the partners of the ICS on the development and refinement of the North east London ICS Operating Principles.
- Address key system issues and:
 - Focus on facilitating agreement between partners on key health and well-being issues and responses;
 - Identify key outcomes and ensure the experience of service users and patients remain at the centre;
 - Set the culture and tone for the ICS through leading by example;
 - Openly discuss difficult issues with a focus on what is best for the North East London population;
 - Provide constructive challenge to the established ways of working;
 - Ensure that the needs of people, places and communities are widely understood.

The membership and participant record of the North East London Integrated Care Partnership (ICP) is outlined in the table below.

| Name of Committee member | 23 Nov 2022 | 11 Jan 2023 | Total attended / total possible |
|--|-------------|-------------|---------------------------------|
| Marie Gabriel CBE, Chair | ✓ | ✓ | 2/2 |
| Zina Etheridge, Chief Executive, NHS North East London | ✓ | ✓ | 2/2 |
| Dr Paul Gilluley, Chief Medical Officer, NHS North East London | ✓ | ✓ | 2/2 |
| Johanna Moss, Chief Strategy & Transformation Officer, NHS North East London | ✓ | ✓ | 2/2 |
| Eileen Taylor, *Chair, East London Foundation Trust | ✓ | ✓ | 2/2 |
| Sultan Taylor, *Interim Chair, North East London Foundation Trust | ✓ | N/A | 1/1 |
| Sir John Gieve, Chair, Homerton Healthcare | ✓ | ✓ | 2/2 |
| Rt Hon Jacqui Smith, Chair, Barts Health and BHR Hospitals Trust | ✓ | ✓ | 2/2 |
| Councillor Maureen Worby, London Borough of Barking & Dagenham | x | ✓ | 1/2 |
| Councillor Mary Durcan, London Borough of City of London | ✓ | x | 1/2 |
| Councillor Christopher Kennedy, London Borough of Hackney | ✓ | ✓ | 2/2 |
| Councillor Gillian Ford, London Borough of Havering | ✓ | ✓ | 2/2 |
| Councillor Neil Wilson, London Borough of Newham | ✓ | ✓ | 2/2 |
| Councillor Mark Santos, London Borough of Redbridge | ✓ | ✓ | 2/2 |
| Councillor Gulam Choudhury, London Borough of Tower Hamlets | x | x | 0/2 |
| Councillor Naheed Asghar, London Borough of Waltham Forest | ✓ | ✓ | 2/2 |
| Pip Salvador-Jones, VCSE rep, Barking & Dagenham | x | x | 0/2 |
| Tony Wong, VCSE rep, Hackney | x | ✓ | 1/2 |
| Paul Rose, VCSE rep, Havering | ✓ | x | 1/2 |
| Caroline Rouse, VCSE rep, Newham | x | x | 0/2 |
| Jenny Ellis, VCSE rep, Redbridge | ✓ | x | 1/2 |
| Peter Okali, VCSE rep, Tower Hamlets | x | N/A | 0/1 |
| Vicky Scott, VCSE rep, Tower Hamlets | N/A | x | 0/1 |
| Manisha Modhvadia, Healthwatch, Barking & Dagenham | x | ✓ | 1/2 |
| Rachel Cleave, Healthwatch, City of London | ✓ | ✓ | 2/2 |
| Catherine Perez Philips, Healthwatch, Hackney | ✓ | ✓ | 2/2 |
| Ian Buckmaster, Healthwatch, Havering | ✓ | ✓ | 2/2 |

| Name of Committee member | 23 Nov 2022 | 11 Jan 2023 | Total attended / total possible |
|--|-------------|-------------|---------------------------------|
| Veronica Awuzudike, Healthwatch, Newham | ✓ | ✓ | 2/2 |
| Cathy Turland, Healthwatch, Redbridge | x | x | 0/2 |
| Matthew Adrienne, Healthwatch, Tower Hamlets | ✓ | ✓ | 2/2 |
| Dianne Barham, Healthwatch, Waltham Forest | ✓ | ✓ | 2/2 |

** Eileen Taylor became joint Chair of East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT) with effect from 1 January 2023*

Meetings are usually open to the public however the first meeting held in November 2022 was held as a development session and was not held in public.

The meeting was also attended regularly by:

- Charlotte Pomery, Chief Participation and Place Officer, NHS NEL
- Marie Price, Director of Communication and Involvement, NHS NEL
- Hilary Ross, Director of Strategic Development, NHS NEL

The following key topics were discussed by the North East London Integrated Care Partnership in 2022/23:

- Role and purpose of the partnership and how it works as a system
- Population health profile
- Development and approval of the interim integrated care partnership strategy
- Development of the joint forward plan

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Broad membership allowed for good debate and challenge.
- Meetings well attended from all sectors

Areas for improvement:

- Holding a meeting in person would enable relationships to be built on further and engage the audience more effectively
- The membership could reflect the population better in terms of diversity

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate the ICB's compliance with the principles set out in the Code (insofar as this applies to ICBs).

Discharge of Statutory Functions

North East London ICB has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Chief Officer. Departments have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

Risk management arrangements and effectiveness

The ICB recognises that the establishment of effective risk management systems is fundamental to ensuring effective governance. The ICB has a risk management assurance framework in place, the aim of which is to continually improve the quality of an integrated health service through the identification, prevention, control and containment of risks of all kinds. It is based on good practice and Department of Health (DH) guidance. The framework supports the assessment and management of risk throughout the organisation through a defined structure and clear systems and processes. It applies to all members, office holders and employees, permanent or temporary, of the ICB.

Capacity to Handle Risk

The Chief Executive Officer provides leadership to the risk management process and, as a member of the ICB Board, ensures that the ICB's approach to risk management is transparent and the organisational structure supports effective systems and processes. The management of risk across each department is led and reported by the relevant Chief Officer with support from the corporate services team. Chief Officers are involved in regular reviews of the risk register and the assurance framework. The Chief Participation and Place Officer presents the Board Assurance Framework (BAF) to each ICB Board meeting. Training is key to encouraging a culture where risk management is seen by the ICB Board members and our staff as essential. Presentations on counter fraud have been provided for all members of staff by the counter fraud officer.

Risks are explicitly discussed and mitigations reviewed at the following meetings which include partners from across the ICS:

- Executive management team meetings
- Finance, performance and investment committee
- Quality, safety and improvement committee
- Population Health and Integration committee
- Audit and risk committee
- ICB Board

The process in place ensures that there are regular forums to collaboratively review the common risks, raise new risks, discuss and constructively challenge the effectiveness of the mitigating actions and suggest changes as appropriate.

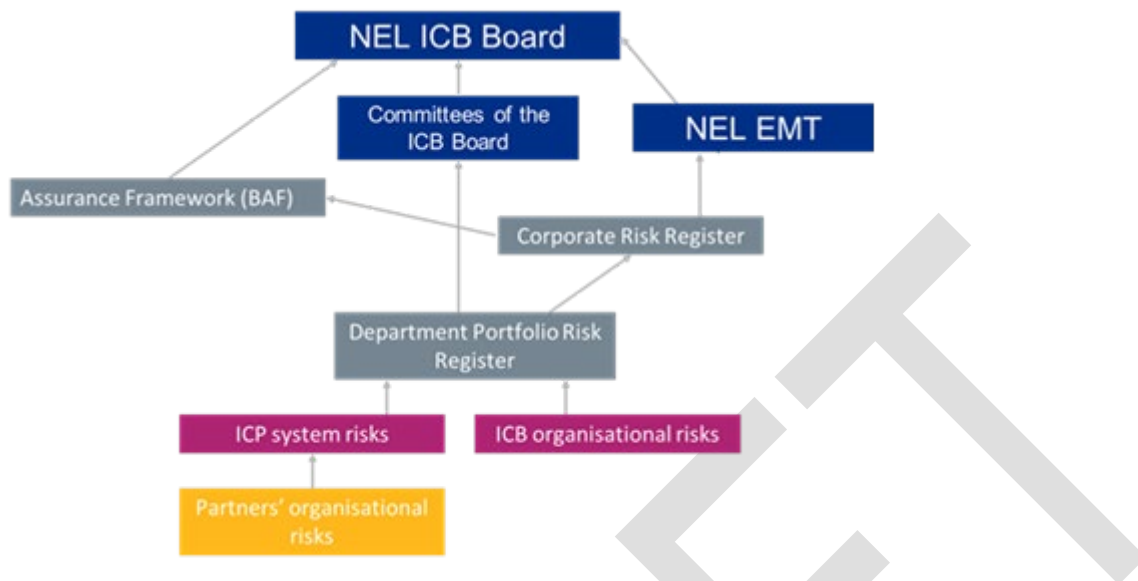
Risk Assessment

The key risks for the ICB during July 2022 – March 2023 have been aligned to the four ICS priorities. The ICB monitors risks closely, as described within the governance statement in this report. The risks on the BAF for the past year related to the following:

- Collaborative working across partners
- Wider determinants of health/environment
- Quality and safety of care
- Delivery against control total and operating plan
- Workforce challenges
- Population growth and impact on services
- Mutual accountability for system wide commitments
- Digital and estates capacity and infrastructure
- Anti-racist commitment

- Being outward rather than inward looking

The risk management structure of the ICB is shown below:



The risk management structure shows the links between the operational level risks at department level, and the strategic risks which are managed at senior organisational or ICB Board level.

Risks are identified in various ways:

- Proactive risk assessments
- Incident reports (including serious incidents and never events)
- Complaints
- Audits
- Serious case reviews
- Feedback from Healthwatch, the patient engagement groups and Health Scrutiny Committees
- Service improvement programmes
- General stakeholder feedback

Risk management is embedded in the organisation in a number of ways. The BAF is presented to every ICB Board meeting to provide context for items related to finance, quality, performance, and strategy.

Declarations of conflicts of interest features at the start of each Board meeting and the register of interests is included at the start of the agenda and within the pack. The register of interests is reviewed periodically by the Audit Chair and a smaller working group of governance and legal officers.

All reports to the Board, Audit and Risk Committee and other committees require a cover sheet which asks document authors to consider the following:

- Risk implications
- Impact on equality, finance and performance
- Impact on local people, health inequalities and sustainability

The risk management policy and strategy are available on the ICB's website, together with policies in relation to standards of business conduct, conflicts of interest, gifts and hospitality, freedom to speak up and fraud prevention.

Risks were discussed with the Chief Officers' Risk Champions bi-monthly and at the ICB's executive management meeting.

Based on criteria set out in the risk management policy and the current risk rating, significant risks are escalated from the corporate risk register to the BAF. Some of the risks that are rated as severe (red rated) are escalated to the BAF where that risk is deemed to pose a significant threat to the achievement of the ICS's strategic objectives. When rating risks, other factors are also taken into consideration, such as whether they are common to a number of departments/functions or where additional controls have not succeeded in reducing the risk grading.

The risk management scoring system is used systematically in each review of the risk register. This ensures that risks are escalated appropriately to the BAF. Risks escalated to the BAF are reviewed with the relevant Chief Officer prior to Board meetings. There is also a yearly audit of our BAF and risk management processes undertaken by the ICB's internal auditors which checks our adherence to policy and best practice.

The Audit and Risk Committee periodically reviews the management process that is in place for the management of risks and receives reports on specific emerging risks and risk mitigation. The organisation's 'risk appetite' is captured for each risk on the BAF.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the ICB to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework. Our internal auditors RSM have completed this audit for the most recent year (2022/23) and gave a rating of substantial assurance. The policy for managing conflicts of interest, building on the good practice and experience within the ICB, is included in the ICB's Governance Handbook.

Data Quality

Data is provided from a range of sources – through our in-house teams and NHS England. There have been no issues of concern raised, however as we progress we look to develop more sophisticated integrated data to support our place-based partnerships and provider collaboratives to succeed.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training. There are processes in place for

incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

Business Critical Models

An appropriate framework and environment is in place to provide quality assurance of business critical models, in line with the recommendations in the Macpherson report. No business critical models have been identified that require information about quality assurance processes for those models to be provided to the Analytical Oversight Committee chaired by the Chief Analyst in the Department of Health and Social Care.

Third party assurances

From 1 July 2022, the ICB and other London ICBs brought many former London Shared Services (LSS), in house. Many services, including contracting, business intelligence and medicines optimisation are now managed within the ICB. Where services are still shared, but hosted by a single organisation, activities are reviewed and monitored through a London wide board. The ICB still contracts for its financial accounting systems with NHS Shared Business Services. The service standards and performance are monitored as part of a service level agreement and the Audit and Risk Committee receives an annual service auditor report on these contracted-for services.

Control Issues

There are no significant control issues currently facing the ICB.

Review of economy, efficiency and effectiveness of the use of resources

The ICB has a comprehensive governance and reporting framework in place to monitor use of resources, identify any issues and ensure the appropriate measures are taken to address any variance from plans. The board receives regular summary reports concerning the ICB's financial performance, and the finance committee has authority to conduct more detailed scrutiny and report back.

The Finance, Performance and Investment Committee convenes regularly to scrutinise the detailed operational financial performance of the ICB.

The Audit and Risk Committee is chaired by the board's Non-executive Member for Governance with additional non-executive membership. The Committee performs the role of oversight and scrutiny of ICB policies, procedures and systems of internal control, and had a focus on ensuring that conflicts of interest are managed in line with the ICB's Constitution.

Underpinning the ICB's governance framework are the Prime Financial Policies, which set out the key business rules that govern the organisation, including internal control, audit, standards of business conduct and budgetary control. They also incorporate the scheme of delegation. This sets out the level of authority to act and make decisions, which has been delegated from the board to the various executive committees, in addition to the authorisation limits set by the board for the management posts within the organisation to authorise expenditure.

Delegation of functions

ICBs were not permitted to delegate any functions externally over the past year. In establishing the new governance arrangements for the organisation and system we have worked with internal and external stakeholders to design governance arrangements that will safely support delegation in future – as intended by the new legislation that established ICBs and which put ICSs and ICPs on a statutory footing.

Counter fraud arrangements

An Accredited Counter Fraud Specialist, RSM UK, is contracted to undertake counter fraud work proportionate to identified risks.

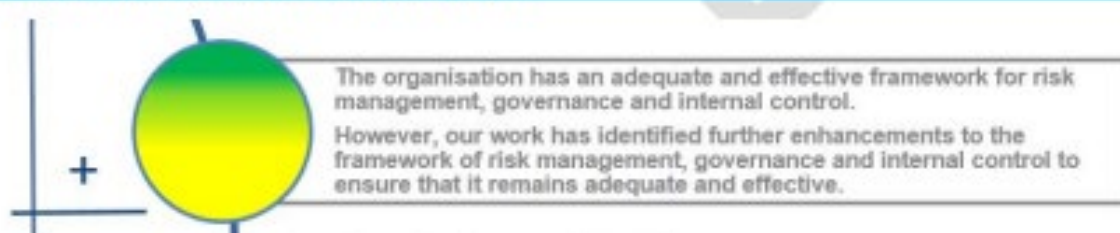
- The ICB Audit and Risk Committee receives a report against each of the 'Standards for Commissioners' at least annually. There is executive support and direction for a proportionate proactive work plan to address identified risks.
- Regular reports are presented to the ICB's Audit and Risk Committee with progress against the work plan, updates on cases and policy updates.
- A member of the board is proactively and demonstrably responsible for tackling fraud, bribery and corruption.
- Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period July 2022 to March 2023 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

For the 9 months ended 31 March 2023, our draft head of internal audit opinion for North East London Integrated Care Board, as at 7 March 2023, is as follows:

Head of internal audit opinion 2022/23



During the period, Internal Audit issued the following audit reports:

| Area of Audit | Level of Assurance Given |
|--|--------------------------|
| IR 35 | Partial Assurance |
| Continuing Healthcare follow-up | Little progress |
| Procurement and Contracts Register | Partial Assurance |
| Medicines Optimisation | Partial Assurance |
| Financial Ledger – Transfer of Balances | Substantial Assurance |
| Conflicts of Interest | Substantial Assurance |
| Data Security and Protection Toolkit | Substantial Assurance |
| Primary Care Commissioning | Reasonable Assurance |
| Governance and Risk Management | Reasonable Assurance |
| Healthcare Financial Management Association Financial Sustainability checklist | Advisory review |
| Delegated Duties – Dental, Optometry and Pharmacy | Advisory review |

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on

performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The board
- The audit and risk committee
- Internal audit

Conclusion

No significant internal control issues have been identified.

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Remuneration and Staff Report

Remuneration Report

Please see the previous section for details on the Remuneration and Workforce Committee.

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in NHS North East London in the financial period ending 31 March 2023 was £245k to £250k.

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

| 2022/23 | 25 th percentile | Median pay ratio | 75 th percentile pay ratio |
|--|-----------------------------|------------------|---------------------------------------|
| Total remuneration (£) | 42,471 | 58,051 | 75,394 |
| Salary component of total remuneration (£) | 42,471 | 58,051 | 75,394 |
| Pay ratio information | 5.83 | 4.26 | 3.28 |

During the reporting period 2022/23, 0 employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £0 to £5k and £245k to £250k. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

The NHS has adopted the recommendations outlined in the Greenbury report in respect of the disclosure of senior managers' remuneration and the manner in which it is determined. Senior managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the ICB. This means those who influence the

decisions of the ICB as a whole rather than the decisions of individual directorates or departments. This report outlines how those recommendations have been implemented by the ICB

The remuneration of senior managers is determined by the Remuneration and Workforce Committee in line with national NHS 'Agenda for Change' and very senior manager pay guidance. The Committee reviews information about director and board member responsibilities, as well as comparing remuneration in similar organisations to set pay. In addition there is a Non-executive Remuneration Committee has a limited role for the special purpose of considering the remuneration of non-executive members of the ICB and associate non-executive members.

Remuneration of Very Senior Managers

During July to April, seven very senior managers combined salary was more than £150,000 per annum (the salary of the prime minister). The chief executive's pay was determined by NHS England and discussed through the former CCG's Remuneration Committee in line with national guidance in 2021/22. In establishing the new Integrated Care Board, a smaller executive team, including mandated board roles was appointed to. The overall number of executive directors to that of the former CCG was reduced, and a smaller team of chief officers with broader portfolios and departments established. The salaries were set in line with ICB executive pay guidance issued by NHSE and agreed by the ICB's Remuneration and Workforce Committee. Salary levels are benchmarked and in line with equivalent roles.

Senior manager remuneration (including salary and pension entitlements) – subject to audit

| Name and Title | 2022/23 | | | | | |
|--|--------------------------|--|---|--|--|-------------------------|
| | Salary (bands of £5,000) | Expense Payments (taxable) to nearest £100 | Performance pay and bonuses (bands of £5,000) | Long term performance pay and bonuses (bands of £5000) | All Pension related benefits (bands of £2,500) ^ | Total (bands of £5,000) |
| | £000s | £s | £000s | £000s | £000s | £000s |
| Marie Gabriel Chair 01/07/2022 - 31/03/2023 | 50 - 55 | 0 | 0 | 0 | n/a | 50 - 55 |
| Zina Etheridge Chief Executive Officer 01/07/2022 - 31/03/2023 | 185 - 190 | 0 | 0 | 0 | 42.5 - 45 | 230 - 235 |
| Rajiv Jaitly Non-executive Member for Audit 01/07/2022 - 07/09/2022 | 0 - 5 | 0 | 0 | 0 | n/a | 0 - 5 |
| Sue Evans Non-executive Member for Audit (Interim) 08/09/2022 - 31/01/2023 | 5 - 10 | 0 | 0 | 0 | n/a | 5 - 10 |
| Cha Patel # Non-executive Member for Audit 12/12/2022 - 31/03/2023 | 5 - 10 | 0 | 0 | 0 | n/a | 5 - 10 |

| | | | | | | |
|---|-----------|---|---|---|-----------|-----------|
| Diane Herbert Non-executive Member for Remuneration and Workforce 01/07/2022 - 31/03/2023 | 10 - 15 | 0 | 0 | 0 | n/a | 10 - 15 |
| Imelda Redmond CBE Non-executive Member for Quality 01/07/2022 - 31/03/2023 | 10 - 15 | 0 | 0 | 0 | n/a | 10 - 15 |
| Dr Paul Gilluley Chief Medical Officer 01/07/2022 - 31/03/2023 | 160 - 165 | 0 | 0 | 0 | 85 - 87.5 | 245 - 250 |
| Diane Jones Chief Nursing Officer 01/07/2022 - 31/03/2023 | 110 - 115 | 0 | 0 | 0 | 62.5 - 65 | 175 - 180 |
| Henry Black Chief Finance and Performance Officer 01/07/2022 - 31/03/2023 | 115 - 120 | 0 | 0 | 0 | 22.5 - 25 | 140 - 145 |
| Charlotte Pomery Chief Participation and Place Officer 01/07/2022 - 31/03/2023 | 110 - 115 | 0 | 0 | 0 | 15 - 17.5 | 125 - 130 |
| Francesca Okosi Chief People and Culture Officer 01/07/2022 - 31/03/2023 | 110 - 115 | 0 | 0 | 0 | 30 - 32.5 | 140 - 145 |
| Johanna Moss Chief Strategy and Transformation Officer 24/10/2022 - 31/03/2023 | 65 - 70 | 0 | 0 | 0 | 20 - 22.5 | 85 - 90 |

| | | | | | | |
|--|---------|---|---|---|-----|---------|
| Dr Jagan John Partner member (Primary care) 01/07/2022 - 31/03/2023 | 10 - 15 | 0 | 0 | 0 | n/a | 10 - 15 |
| Dr Mark Ricketts Partner member (Primary care) 01/07/2022 - 31/03/2023 | 10 - 15 | 0 | 0 | 0 | n/a | 10 - 15 |
| Paul Calaminus* ELFT Partner member (NHS trusts and foundation trusts) 01/07/2022 - 31/03/2023 | | | | | | |
| Shane De Garis* Barts/BHRUT Group Partner member (NHS trusts and foundation trusts) 01/07/2022 - 31/03/2023 | | | | | | |
| Councillor Maureen Worby* London Borough of Barking & Dagenham Partner member (Local Authority) 20/07/2022 - 31/03/2023 | | | | | | |
| Mayor Philip Glanville* London Borough of Hackney Partner member (Local Authority) 20/07/2022 - 31/03/2023 | | | | | | |
| Caroline Rouse* Partner member (Voluntary, community and social enterprise sector) 01/08/2022 - 31/03/2023 | | | | | | |

* Partner Member of the ICB Board for whom no costs are incurred by the ICB

^ Pension Related Benefits reflect a proportion of the full increase for the year ended 31 March 2023.

Induction Period 12/12/2022 - 31/01/2023

Pension benefits of senior managers as at 31 March 2023 - subject to audit

The following schedule discloses further information regarding pension entitlements

| Name & Title | Real increase in pension at pension age (bands of £2,500) | Real increase in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31st March 2023 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31st March 2023 (bands of £5,000) | Cash Equivalent Transfer Value at 1st July 2022 | Real increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31st March 2023 | Employer's contribution to stakeholder pension |
|------------------|---|--|---|---|---|---|---|--|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Zina Etheridge | 2 - 2.5 | 0 | 5 - 10 | 0 | 21 | 18 | 65 | 0 |
| Diane Jones | 2 - 2.5 | 2.5 - 5 | 40 - 45 | 65 - 70 | 663 | 56 | 750 | 0 |
| Dr Paul Gilluley | 5 - 7.5 | 5 - 7.5 | 80 - 85 | 160 - 165 | 1,439 | 89 | 1,583 | 0 |
| Henry Black | 2 - 2.5 | 0 | 40 - 45 | 65 - 70 | 621 | 14 | 665 | 0 |
| Charlotte Pomery | 0 - 2.5 | 0 | 0 - 5 | 0 | 0 | 7 | 30 | 0 |
| Francesca Okosi | 0 - 2.5 | 0 | 15 - 20 | 0 | 229 | 24 | 285 | 0 |
| Johanna Moss | 0 - 2.5 | 0 - 2.5 | 40 - 45 | 65 - 70 | 546 | 13 | 596 | 0 |

The ICB was only able to obtain information for pension entitlements for the period ending 31 March 2023. As a result estimated values for CETV as at 1 July 2022 have been calculated incorporating a proportion of the increase during 2022-23; this is considered to be reasonable approximation for the values reported for 1 July 2022. The real increases in pension and lump sum have been calculated as a proportion of the full increase for the year ended 31 March 2023.

Note: CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement of for loss of office

No compensation on early retirement for loss of office was made during the financial year.

Payments to past directors

No payments were made to past directors during the financial year.

Staff Report

Number of senior managers

| Senior Manager | Head Count |
|------------------------|------------|
| Band 9 + Clinical Lead | 98 |
| Consultant Lead | 1 |
| VSM | 15 |
| Total | 114 |

Staff costs

| | Total | | 2022-23 |
|--|------------------------------|----------------|----------------|
| | Permanent Employees £'000 | Other £'000 | Total £'000 |
| Employee Benefits | | | |
| Salaries and wages | 38,056 | 10,033 | 48,089 |
| Social security costs | 4,712 | 84 | 4,796 |
| Employer contributions to the NHS Pension Scheme | 6,528 | 88 | 6,616 |
| Other pension costs | 6 | - | 6 |
| Apprenticeship Levy | 198 | - | 198 |
| Termination benefits | 673 | - | 673 |
| Total employee benefits expenditure | 50,173 | 10,205 | 60,378 |

Staff composition

Employee group

| NEL ICB | Female | Male | Total |
|------------------------|------------|------------|------------|
| NEL ICB employees | 534 | 367 | 901 |
| NEL ICB office holders | 41 | 31 | 72 |
| Total | 575 | 398 | 973 |

Gender

| Gender | Head Count |
|--------------|------------|
| Female | 575 |
| Male | 398 |
| Total | 973 |

Declared disability

| Disability | Headcount |
|----------------------|------------|
| No | 799 |
| Not Declared | 75 |
| Prefer Not To Answer | 23 |
| Unspecified | 24 |
| Yes | 52 |
| Total | 973 |

Ethnicity

| Ethnic origin | Head Count |
|---|------------|
| A White – British | 342 |
| B White – Irish | 20 |
| C White - Any other White background | 37 |
| C2 White Northern Irish | 2 |
| C3 White Unspecified | 1 |
| CA White English | 14 |
| CB White Scottish | 3 |
| CC White Welsh | 1 |
| CF White Greek | 1 |
| CK White Italian | 2 |
| CN White Gypsy/Romany | 1 |
| CP White Polish | 1 |
| CX White Mixed | 1 |
| CY White Other European | 8 |
| D Mixed - White & Black Caribbean | 12 |
| E Mixed - White & Black African | 5 |
| F Mixed - White & Asian | 4 |
| G Mixed - Any other mixed background | 10 |
| GA Mixed - Black & Asian | 2 |
| GC Mixed - Black & White | 2 |
| GD Mixed - Chinese & White | 1 |
| GF Mixed - Other/Unspecified | 5 |
| H Asian or Asian British – Indian | 86 |
| J Asian or Asian British – Pakistani | 25 |
| K Asian or Asian British – Bangladeshi | 69 |
| L Asian or Asian British - Any other Asian background | 13 |

| Ethnic origin | Head Count |
|---|-------------------|
| LB Asian Punjabi | 8 |
| LC Asian Kashmiri | 1 |
| LD Asian East African | 3 |
| LF Asian Tamil | 2 |
| LH Asian British | 3 |
| LK Asian Unspecified | 3 |
| M Black or Black British – Caribbean | 40 |
| N Black or Black British – African | 87 |
| P Black or Black British - Any other Black background | 5 |
| PC Black Nigerian | 6 |
| PD Black British | 27 |
| PE Black Unspecified | 1 |
| R Chinese | 11 |
| S Any Other Ethnic Group | 6 |
| SA Vietnamese | 1 |
| SC Filipino | 3 |
| SD Malaysian | 1 |
| SE Other Specified | 5 |
| Unspecified | 12 |
| Z Not Stated | 80 |
| Total | 973 |

Religion

| Religious Belief | Head Count |
|--|-------------------|
| Atheism | 132 |
| Buddhism | 6 |
| Christianity | 331 |
| Hinduism | 51 |
| I do not wish to disclose my religion/belief | 212 |
| Islam | 118 |
| Jainism | 3 |
| Judaism | 9 |
| Other | 62 |
| Sikhism | 28 |
| Unspecified | 21 |
| Total | 973 |

Age

| Age Range | Head Count |
|--------------|------------|
| <=20 Years | 1 |
| >=71 Years | 3 |
| 21-25 | 28 |
| 26-30 | 71 |
| 31-35 | 133 |
| 36-40 | 168 |
| 41-45 | 156 |
| 46-50 | 123 |
| 51-55 | 128 |
| 56-60 | 101 |
| 61-65 | 53 |
| 66-70 | 8 |
| Total | 973 |

Sexual orientation

| Sexual Orientation | Head Count |
|--|------------|
| Bisexual | 13 |
| Gay or Lesbian | 35 |
| Heterosexual or Straight | 758 |
| Not stated (person asked but declined to provide a response) | 143 |
| Other sexual orientation not listed | 1 |
| Undecided | 2 |
| Unspecified | 21 |
| Total | 973 |

Sickness absence data

| | Average FTE for 2022 | Average Annual Sick Days per FTE | Sum of FTE Days Sick | Sum of FTE Days Available |
|-----------------------|----------------------|----------------------------------|----------------------|---------------------------|
| North East London ICB | 813 | 4.8 | 4,203 | 197,844 |

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse

Period covered: January to December 2022

NHS Digital Statistics

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Staff turnover percentages

| | 2022 / 04 | 2022 / 05 | 2022 / 06 | 2022 / 07 |
|--------------------------------------|-----------|-----------|-----------|-----------|
| Turnover Rate (Headcount) | 1.26% | 1.26% | 1.83% | 1.14% |

Staff policies and support

The ICB continued with a developmental programme of work to create a more compassionate, inclusive and collaborative environment, where people can bring their whole selves to work create meaningful improvements in health, wellbeing and equality for the people of north east London.

Reverse mentoring

The ICB launched and ran a second round of reverse mentoring where a person in a senior position is mentored by someone in a more junior position; giving senior staff insight into what it is like to be working at our organisation with a protected characteristic, with mentors sharing their lived experience of this. The relationship provides a space for staff to explore areas of good practice and generate ideas and priorities for improving inclusion and equity in the organisation. This round saw 20 new pairs matched and meet in a reverse mentoring relationship for six months, with all members of the senior team being mentored. Learning from the evaluation with evidence impact and steer next steps for this important intervention.

Staff support programme as part of our organisational restructure

To support people through our organisational restructure and consultation we commissioned training and support for staff and managers to equip them with the skills and knowledge to undertake consultation and selection well, support and manage mental wellbeing, build resilience and equip people to move forward successfully during this period of transition. The mental wellbeing for all programme supported staff to be more aware of and manage their own wellbeing, with managers undertaking a second session to enable them to discuss mental wellbeing with their teams, how to spot if a team member is showing signs of mental distress and what to do if that is the case. Skills based training for leaders focussed on managing teams through organisational change and for all staff, selection skills including CV, application writing and interview skills, aims to ensure people are well equipped to undertake change processes, with support about how to make the best decision for them.

Staff wellbeing support and resources

Our 'one stop shop' staff wellbeing hub, brings together the most important and impactful resources to enable and support the wellbeing of staff, including links and resources to support people with the rising cost of living. KeepingWellNEL provides confidential, independent and

inclusive wellbeing support, advice and resources to health and care staff across north east London. With a holistic approach the service supports wellbeing in ways that are most reflective of people's needs, with wellbeing advisors available 8am-8pm Monday-Saturday [Keeping Well Nel.](#)

Always learning

We continue to support staff with access to the range of interactive webinars, virtual workshops and learning resources, across topics and themes, through NHS Elect and promote the best learning opportunities available externally through partners such as the NHS Leadership Academy, King's Fund and local training hubs.

We have a number of staff completing coaching apprenticeships; equipping them with the skills to support experiential learning so vital in changing and complex environments and seeing them develop their coaching practice, as well as supporting people in the organisation with coaching opportunities.

With a current focus on supporting people with the skills and resources to undertake and manage organisational change well, we then plan to focus on establishing a learning and development approach that supports our organisation and our people to be successful now and into the future, with a clear priority around equality of opportunity and access to learning and development.

Staff engagement

72% of staff responded to the 2022 staff survey. Working with staff and senior leaders, we are establishing a set of priority improvements that can be undertaken quickly to improve staff experience, as well as working with our survey provider to understand the areas that have the biggest impact on staff experience, giving us a thematic focus to design changes with staff that matter most to them.

Staff networks

Our staff networks have been formed to find innovative solutions to systemic problems, further our organisational commitment to equality and diversity, discuss issues affecting staff with senior leaders and provide a safe space for people to raise their concerns. Having been established for a over two years, the networks continue to develop and build their areas of focus, with events, resources and training across a range of topics and activities for important national campaigns, observances and celebrations including LGBTQ+, Black History and Disability History Months.

Guardian service

A new independent and confidential Freedom to Speak up Guardian Service was launched at the beginning of 2023, available for any members of staff to discuss matters relating to patient care and safety, whistleblowing, bullying and harassment, and work grievances. Available 24/7, the service provides information and emotional support in a strictly confidential, non-judgemental manner and in an off-the-record discussion. As an alternative and impartial way to speak up and be supported with next steps, the service works with the organisation to address the concerns and incidents raised. It is also assisting in thinking through a system approach to F2SU as we work towards more integrated teams.

Hybrid working

Our hybrid working and estates working group is focussing on how we use our office estate and the development of our hybrid working model. With representatives from across the organisation and our staff networks, the group has recently focussed on using space effectively, developing our desk booking system and improving our IT infrastructure.

Our hybrid working model will continue to develop, with a focus on culture and best practice ways of working to support people to work well and effectively for the people of north east London.

Staff policies

Following work by the former CCG a number of staff policies including Pay Protection and Organisational Change Policies were revised with input from Trade Union, staff network and management representatives. These provide greater equity and consistency across the organisation, with a focus on ensuring more inclusive language and processes to ensure improvements of experiences for staff and potential candidates who have protected characteristics. This work has been important given the nationally mandated management savings for ICBs, and subsequent all-staff consultation launch proposing a new structure including a reduction in headcount.

Improvements to recruitment and selection processes and practices continue. These include improving access and experience for disabled candidates through the recruitment process. We offer interviews to all disabled applicants, providing their application scores sufficiently highly against the essential criteria for the job.

Trade Union Facility Time Reporting Requirements

Percentage of pay bill spent on facility time

| | £000's |
|---|--------|
| Provide the total cost of facility time | 12 |
| Provide the total pay bill | 60,378 |
| Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100 | 0.02% |

Paid trade union activities

| | |
|--|-------|
| Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100 | 12.5% |
|--|-------|

Other employee matters

NHS London Shared Service consulted its staff on a move to other NHS organisations in London. The 30-day consultation launched on 26 April for staff at NHS London Shared Service (formerly NEL CSU), who were consulted on their proposed assignment to four London CCGs and other receiving organisations in London. The consultation concluded on 26 May 2022. The mechanism of transfer for LSS staff to their receiver organisations was a combination of Transfer Scheme, TUPE and COSOP (also known as TUPE-like), underpinned by the overarching principles of an employment commitment for all and protection of employment, which guided the consultation. Staff joined the new organisation in July, but were engaged as much as possible in advance of the transfer.

Expenditure on consultancy

Consultancy expenditure in 2022-23 was £1,087k.

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2023 for more than £245* per day:

| | Number |
|--|--------|
| Number of existing engagements as of 31 March 2023 | 94 |
| <i>Of which, the number that have existed:</i> | |
| for less than one year at the time of reporting | 94 |
| for between one and two years at the time of reporting | 0 |
| for between 2 and 3 years at the time of reporting | 0 |
| for between 3 and 4 years at the time of reporting | 0 |
| for 4 or more years at the time of reporting | 0 |

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The ICB confirms that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 July 2022 and 31 March 2023, for more than £245⁽¹⁾ per day:

| | Number |
|--|--------|
| No. of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023 | 162 |
| <i>Of which:</i> | |
| No. not subject to off-payroll legislation ⁽²⁾ | 0 |
| No. subject to off-payroll legislation and determined as in-scope of IR35 ⁽²⁾ | 152 |
| No. subject to off-payroll legislation and determined as out of scope of IR35 ⁽²⁾ | 10 |
| the number of engagements reassessed for compliance or assurance purposes during the year | 0 |
| Of which: no. of engagements that saw a change to IR35 status following review | 0 |

⁽¹⁾ The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

⁽²⁾ A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must

undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 July 2022 and 31 March 2023:

| | |
|---|----|
| Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period | 0 |
| Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements. | 15 |

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Exit packages, including special (non-contractual) payments

| Exit package cost band (inc. any special payment element) | Compulsory redundancies | |
|---|-------------------------|----------------|
| | Number | £s |
| £10,000 - £25,000 | 1 | 14,861 |
| £150,001 - £200,000 | 2 | 320,000 |
| TOTALS | 3 | 334,861 |

This table reports the number and value of exit packages agreed in the financial period. No special payments were made. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Compulsory Redundancy Scheme.

Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table; there was one ill health early retirement during the reporting period, cost £107,058.

Parliamentary Accountability and Audit Report

NEL ICB is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report at page 51]. An audit certificate and report is also included in this Annual Report at [insert page reference].

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ANNUAL ACCOUNTS

DRAFT

Zina Etheridge
Accountable Officer
XX month 2023

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Statement of Comprehensive Net Expenditure for the period ended 31 March 2023

| | Note | 2022-23 £'000 |
|---|------|------------------|
| Other operating income | 2 | (18,014) |
| Total Operating Income | | (18,014) |
| Staff costs | 4 | 60,378 |
| Purchase of goods and services | 5 | 3,140,537 |
| Depreciation and impairment charges | 5 | 2,434 |
| Provision expense | 5 | 462 |
| Other operating expenditure | 5 | 214 |
| Total Operating Expenditure | | 3,204,025 |
| Net Operating Expenditure | | 3,186,011 |
| Finance expense | 7 | 76 |
| Net Expenditure for the Period | | 3,186,087 |
| Comprehensive Expenditure for the Period | | 3,186,087 |

The ICB received a revenue resource limit of £3,186,125k for 2022-23; Net Expenditure for the period was £3,186,087k, therefore, the ICB recorded an underspend of £38k.

Statement of Financial Position as at
31 March 2023

| | | 31st March 2023 | 1st July 2022 |
|--|------|------------------|------------------|
| | Note | £'000 | £'000 |
| Non-current Assets | | | |
| Property, plant and equipment | 9 | 763 | 1,053 |
| Right-of-use assets | 11 | 9,547 | 11,185 |
| Intangible assets | 10 | - | 43 |
| Total Non-current Assets | | 10,310 | 12,281 |
| Current Assets | | | |
| Trade and other receivables | 12 | 24,846 | 29,076 |
| Cash and cash equivalents | 13 | 38 | - |
| Total Current Assets | | 24,884 | 29,076 |
| Total Assets | | 35,194 | 41,357 |
| Current Liabilities | | | |
| Trade and other payables | 14 | (314,472) | (305,751) |
| Lease liabilities | 11 | (2,497) | (1,964) |
| Borrowings | | - | (14,319) |
| Provisions | 15 | (18,686) | (17,097) |
| Total Current Liabilities | | (335,655) | (339,131) |
| Non-current Assets less Net Current Liabilities | | (300,461) | (297,774) |
| Non-current Liabilities | | | |
| Lease liabilities | 11 | (7,158) | (9,241) |
| Provisions | 15 | (100) | (907) |
| Total Non-current Liabilities | | (7,258) | (10,148) |
| Assets less Liabilities | | (307,719) | (307,922) |
| Financed by Taxpayers' Equity | | | |
| General fund | | (307,719) | (307,922) |
| Total Taxpayers' Equity | | (307,719) | (307,922) |

The notes on pages x to xx form part of this statement

The balances as at 1st July 2022 relate to those transferred by modified absorption (note 8).

The financial statements on pages [] to [] were approved by the Board on [date] and signed on its behalf by:

Zina Etheridge
Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the period ended
31 March 2023

| | Note | General Fund 2022-23 £'000 |
|--|------|----------------------------------|
| Changes in Taxpayers' Equity for the Financial Period | | |
| Balance at 1 July 2022 | | - |
| Transfers by modified absorption from other bodies | 8 | (307,922) |
| Adjusted Balance at 1 July 2022 | | <u>(307,922)</u> |
| Changes in NHS Integrated Care Board Taxpayers' Equity for the Financial Period | | |
| Net operating expenditure for the financial period | | (3,186,087) |
| Net Recognised NHS Integrated Care Board Expenditure for the Financial Period | | <u>(3,186,087)</u> |
| Net funding | | 3,186,290 |
| Balance at 31 March 2023 | | <u>(307,719)</u> |

Statement of Cash Flows for the period ended
31 March 2023

| | Note | 2022-23 £'000 |
|---|------|---------------------------|
| Cash Flows from Operating Activities | | |
| Net operating expenditure for the financial period | | (3,186,087) |
| Depreciation and amortisation | 5 | 2,434 |
| Movement due to transfer by modified absorption | 8 | (308,998) |
| Interest paid | 7 | 76 |
| Increase in trade and other receivables | 12 | (24,846) |
| Increase in trade and other payables | 14 | 314,472 |
| Increase in provisions | 15 | 18,786 |
| Net Cash Outflow from Operating Activities | | <u>(3,184,163)</u> |
| Cash Flows from Financing Activities | | |
| Grant in aid funding received | | 3,186,290 |
| Repayment of lease liabilities - Capital | | (2,014) |
| Repayment of lease liabilities - Interest | | (75) |
| Net Cash Inflow from Financing Activities | | 3,184,201 |
| Net Increase in Cash and Cash Equivalents | 13 | <u>38</u> |
| Cash and Cash Equivalents at the beginning of the Financial Period | | - |
| Cash and Cash Equivalents (including bank overdrafts) at the end of the Financial Period | | <u>38</u> |

The notes on pages x to xx form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to ICBs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

As at 31st March 2023 the ICB had net liabilities of £307,719,000.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future and there is no expectation that commissioning will cease to be delivered by the public sector within North East London.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCGs). ICBs took on the commissioning functions of CCGs; CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

For transfers of assets and liabilities from those bodies that closed on 30 June 2022 a modified absorption approach was applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Joint Arrangements

Arrangements over which the ICB has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the ICB is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

1.5 Pooled Budgets

The ICB has entered into pooled budget arrangements with the London Boroughs of Barking & Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest and the City of London in accordance with section 75 of the NHS Act 2006. These are joint arrangements in the form of joint operations.

The ICB has assessed the accounting treatment of the pooled budget arrangements having regard to IFRS10, IFRS11, and IAS28. The ICB has assessed that while joint control over the pooled budgets is present, the substance of the arrangements is that the parties to the pooled budgets are each responsible for commissioning services from providers, with the risks and rewards arising from the contractual obligation remaining with each respective commissioner. The ICB has therefore recognised in its financial statements:

- The assets it controls
- The liabilities it controls
- The expenses it incurs
- Its share of the income from the pooled budget activities

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

Notes to the financial statements

The main source of funding for the ICB is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 Property, Plant & Equipment

1.9.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

Notes to the financial statements

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

No revaluations took place during this period.

1.9.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10 Intangible Assets

1.10.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

1.10.2 Measurement

Intangible assets acquired separately are initially recognised at cost.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.10.3 Depreciation, Amortisation and Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.

The ICB assesses whether a contract is or contains a lease, at inception of the contract. Leases are accounted for in accordance with IFRS 16.

1.11.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

Notes to the financial statements

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

Irrecoverable VAT is expensed in the period to which it relates and, therefore, not included in the measurement of the lease liability and consequently the value of the right-of-use asset.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.12 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.13 Provisions

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

1.14 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the ICB.

1.15 Non-clinical Risk Pooling

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.16 Financial Assets

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

All the ICB's financial assets are categorised as financial assets at amortised cost.

1.16.1 Financial Assets at Amortised Cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

Notes to the financial statements

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.18 Value Added Tax

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign Currencies

The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

1.20 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.21 Critical accounting judgements and key sources of estimation uncertainty

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.21.1 Critical accounting judgements in applying accounting policies

These are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The ICB made no judgements in the period that would have a material effect on the amounts recognised in the financial statements.

1.21.2 Sources of estimation uncertainty

These are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

The ICB had no material key sources of estimation uncertainty in the period.

1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 New and revised IFRS Standards in issue but not yet effective

- IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

IFRS 14 is not applicable to the ICB and IFRS17, if applied in 2022-23, would not have a material impact on the accounts.

2. Other Operating Revenue

| | 2022-23 Total £'000 |
|--------------------------------------|---------------------------|
| Other non contract revenue | 18,014 |
| Total Other Operating Revenue | 18,014 |

Other Operating Revenue does not include cash received from NHS England; this is drawn down directly into the ICB's bank account and credited to the General Fund.

3. Revenue

Revenue is generated wholly from the supply of services; the ICB receives no revenue from the sale of goods.

4. Employee Benefits and Staff numbers

4.1 Employee Benefits

| | 2022-23 | | |
|--|---------------------------------|----------------|----------------|
| | Permanent Employees £'000 | Other £'000 | Total £'000 |
| Salaries and wages | 38,056 | 10,033 | 48,089 |
| Social security costs | 4,712 | 84 | 4,796 |
| Employer Contributions to NHS Pension scheme | 6,528 | 88 | 6,616 |
| Other pension costs | 6 | - | 6 |
| Apprenticeship levy | 198 | - | 198 |
| Termination benefits | 673 | - | 673 |
| Gross Employee Benefits Expenditure | 50,173 | 10,205 | 60,378 |

4.2 Average Number of People Employed

| | 2022-23 | | |
|--------------|-----------------------------------|-----------------|-----------------|
| | Permanently Employed Number | Other Number | Total Number |
| Total | 799.39 | 145.49 | 944.88 |

4.3 Exit Packages Agreed in the Financial Period

| | 2022-23 Compulsory Redundancies | |
|----------------------|------------------------------------|----------------|
| | Number | £ |
| £10,001 to £25,000 | 1 | 14,861 |
| £150,001 to £200,000 | 2 | 320,000 |
| Total | 3 | 334,861 |

This table reports the number and value of exit packages agreed in the financial period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Compulsory Redundancy Scheme.

Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table; there was one ill health early retirement during the reporting period, cost £107,058.

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating Expenses

| | 2022-23 |
|--|-------------------------|
| | Total |
| | £'000 |
| Purchase of Goods and Services | |
| Services from other ICBs and NHS England | 469 |
| Services from foundation trusts | 815,205 |
| Services from other NHS trusts | 1,377,872 |
| Purchase of healthcare from non-NHS bodies | 351,601 |
| Purchase of social care | 27,627 |
| Prescribing costs | 214,320 |
| General ophthalmic services | 127 |
| GPMS/APMS and PCTMS | 286,103 |
| Supplies and services – general | 35,823 |
| Consultancy services | 1,087 |
| Establishment | 15,282 |
| Transport | 106 |
| Premises | 6,206 |
| Audit fees | 258 |
| Other non statutory audit expenditure | |
| Other services | 18 |
| Other professional fees | 5,051 |
| Legal fees | 764 |
| Education, training and conferences | 2,618 |
| Total Purchase of Goods and Services | <u>3,140,537</u> |
| Depreciation and Impairment Charges | |
| Depreciation | 2,391 |
| Amortisation | 43 |
| Total Depreciation and Impairment Charges | <u>2,434</u> |
| Provision Expense | |
| Provisions | 462 |
| Total Provision Expense | <u>462</u> |
| Other Operating Expenditure | |
| Chair and Non Executive Members | 188 |
| Expected credit loss on receivables | 26 |
| Total Other Operating Expenditure | <u>214</u> |
| Total Operating Expenditure | <u>3,143,647</u> |

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the ICB is required to disclose the limit of its external auditors liability. The contract signed states that the liability of KPMG, its members, partners and staff (whether in contract, negligence, or otherwise) shall in no circumstances exceed £1m, aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

External Audit Fees Payable (Excluding VAT)

| | 2022-23 |
|-------------------------|-----------------------|
| | £ |
| Statutory audit fee | 215,000 |
| Other audit services | 15,000 |
| Total Audit Fees | <u>230,000</u> |

These amount exclude VAT; the audit fees included within Note 5 include VAT.

6.1 Better Payment Practice Code

| Measure of Compliance | Number | 2022-23 £'000 |
|--|---------------|------------------|
| Non-NHS Payables | | |
| Total Non-NHS trade invoices paid in the period | 71,561 | 800,821 |
| Total Non-NHS trade Invoices paid within target | 69,236 | 784,176 |
| Percentage of Non-NHS Trade Invoices Paid within Target | 96.75% | 97.92% |
| NHS Payables | | |
| Total NHS Trade invoices paid in the period | 3,559 | 2,215,486 |
| Total NHS Trade invoices paid within target | 3,474 | 2,209,496 |
| Percentage of NHS Trade Invoices Paid within Target | 97.61% | 99.73% |

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

| | 2022-23 £'000 |
|---|------------------|
| Amounts included in finance costs from claims made under this legislation | 1 |
| Total | 1 |

7. Finance Costs

| | 2022-23 £'000 |
|---|------------------|
| Interest | |
| Interest on lease liabilities | 75 |
| Interest on late payment of commercial debt | 1 |
| Total Finance Costs | 76 |

8. Net loss on Transfer by Absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. For the transfer of assets and liabilities from the CCG to the ICB a modified absorption approach was applied; the resulting gain or loss was, therefore, recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

| | 2022-23 NHS England Group Entities (non parent) £'000 |
|--|--|
| Transfer of property plant and equipment | 1,053 |
| Transfer of right of use assets | 11,185 |
| Transfer of intangibles | 43 |
| Transfer of receivables | 29,076 |
| Transfer of payables | (305,751) |
| Transfer of provisions | (18,004) |
| Transfer of right of use liabilities | (11,205) |
| Transfer of borrowings | (14,319) |
| Net Loss on Transfers by Absorption | (307,922) |

9. Property, Plant and Equipment

| 2022-23 | Plant & Machinery £'000 | Information Technology £'000 | Furniture & Fittings £'000 | Total £'000 |
|---|----------------------------|---------------------------------|-------------------------------|----------------|
| Cost or Valuation at 1 July 2022 | - | - | - | - |
| Disposals other than by sale | - | (3,676) | - | (3,676) |
| Transfer from other public sector body | 1,498 | 4,560 | 698 | 6,756 |
| Cost/Valuation at 31 March 2023 | 1,498 | 884 | 698 | 3,080 |
| Depreciation 1 July 2022 | - | - | - | - |
| Disposals other than by sale | - | (3,676) | - | (3,676) |
| Charged during the period | 103 | 131 | 55 | 289 |
| Transfer from other public sector body | 1,064 | 4,244 | 396 | 5,704 |
| Depreciation at 31 March 2023 | 1,167 | 699 | 451 | 2,317 |
| Net Book Value at 31 March 2023 | 331 | 185 | 247 | 763 |
| Purchased | 331 | 185 | 247 | 763 |
| Total at 31 March 2023 | 331 | 185 | 247 | 763 |
| Asset Financing | | | | |
| Owned | 331 | 185 | 247 | 763 |
| Total at 31 March 2023 | 331 | 185 | 247 | 763 |

Revaluation Reserve Balance for Property, Plant and Equipment

No balances are held in the revaluation reserve for any of the Property, Plant and Equipment Assets.

9.1 Economic Lives

| | Minimum Life (years) | Maximum Life (Years) |
|------------------------|-------------------------|-------------------------|
| Plant & machinery | 2 | 5 |
| Information technology | 1 | 5 |
| Furniture & fittings | 3 | 6 |

10. Intangible Non-current Assets

| 2022-23 | Computer Software: Purchased £'000 |
|--|--|
| Cost or Valuation at 1 July 2022 | - |
| Disposals other than by sale | (284) |
| Transfer from other public sector body | 284 |
| Cost / Valuation At 31 March 2023 | - |
| Amortisation 1 July 2022 | - |
| Disposals other than by sale | (284) |
| Charged during the period | 43 |
| Transfer from other public sector body | 241 |
| Amortisation At 31 March 2023 | - |
| Net Book Value at 31 March 2023 | - |
| Purchased | - |
| Total at 31 March 2023 | - |

Revaluation Reserve Balance for Intangible Assets

No balance is held in the revaluation reserve for any of the Intangible Assets.

11. Leases

11.1. Right-of-use Assets

| 2022-23 | Buildings excluding Dwellings £'000 | Information Technology £'000 | Total £'000 | Of which: leased from DHSC group bodies £'000 |
|--|--|------------------------------------|----------------|--|
| Cost or Valuation at 1 July 2022 | - | - | - | - |
| Additions | - | 464 | 464 | - |
| Transfer from other public sector body | 11,685 | 172 | 11,857 | 4,099 |
| Cost/Valuation at 31 March 2023 | 11,685 | 636 | 12,321 | 4,099 |
| Depreciation 1 July 2022 | - | - | - | - |
| Charged during the period | 1,951 | 151 | 2,102 | 1,047 |
| Transfer from other public sector body | 646 | 26 | 672 | 349 |
| Depreciation at 31 March 2023 | 2,597 | 177 | 2,774 | 1,396 |
| Net Book Value at 31 March 2023 | 9,088 | 459 | 9,547 | 2,703 |
| Net Book Value by Counterparty | | | | |
| Leased from other group bodies (NHS Property Services and Community Health Partnerships) | | | | 2,703 |
| Net Book Value at 31 March 2023 | | | | 2,703 |

11.2 Lease Liabilities

| | 2022-23 £'000 |
|---|------------------|
| Lease Liabilities at 1 July 2022 | - |
| Additions purchased | (464) |
| Interest expense relating to lease liabilities | (75) |
| Repayment of lease liabilities (including interest) | 2,089 |
| Transfer from other public sector body | (11,205) |
| Lease Liabilities at 31 March 2023 | (9,655) |

11.3 Lease Liabilities - Maturity Analysis of Undiscounted Future Lease Payments

| | 2022-23 £'000 | Of which: leased from DHSC group bodies £'000 |
|--|------------------|--|
| Within one year | (2,575) | (1,351) |
| Between one and five years | (5,369) | (1,452) |
| After five years | (1,964) | - |
| Balance at 31 March 2023 | (9,908) | (2,803) |
| Effect of Discounting | 253 | 29 |
| Included in | | |
| Current lease liabilities | (2,497) | (1,332) |
| Non-current lease liabilities | (7,158) | (1,442) |
| Balance at 31 March 2023 | (9,655) | (2,774) |
| Balance by Counterparty | | |
| Leased from other group bodies (NHS Property Services and Community Health Partnerships) | | (2,774) |
| Balance as at 31 March 2023 | | (2,774) |

11.4 Amounts Recognised in Statement of Comprehensive Net Expenditure

| | 2022-23 £'000 |
|---|------------------|
| Depreciation expense on right-of-use assets | 2,102 |
| Interest expense on lease liabilities | 75 |

11.5 Amounts Recognised in Statement of Cash Flows

| | 2022-23 £'000 |
|--|------------------|
| Total cash outflow on leases under IFRS 16 | 2,089 |

The majority of the ICB's leases, set up as right-of-use assets, relate to buildings used as administrative centres at locations across its geographical area. The most significant of these are at Unex Tower in Stratford and North House in Romford. Space is also leased at a number of properties from both Community Health Partnerships (Vicarage Lane Health Centre in Stratford, Kenworthy Road Health Centre in Hackney and Beaumont House at Mile End Hospital) and NHS Property Services (St Leonards Hospital).

Two additional building leases, with West Drylining & Facades Limited and Moreland Limited, are held for the management of IT services. Leases relating to the rental of servers are also held with Crown Hosting Data Centres Limited.

12.1 Trade and Other Receivables

| | Current 2022-23 £'000 |
|--|--------------------------------------|
| NHS receivables: revenue | 9,079 |
| NHS accrued income | 2,834 |
| Non-NHS and other WGA receivables: revenue | 7,819 |
| Non-NHS and other WGA prepayments | 487 |
| Non-NHS and other WGA accrued income | 3,605 |
| Expected credit loss allowance-receivables | (54) |
| VAT | 1,068 |
| Other receivables and accruals | 8 |
| Total Trade and Other Receivables | 24,846 |

12.2 Receivables Past their Due Date but not Impaired

| | 2022-23 DHSC Group Bodies £'000 | 2022-23 Non DHSC Group Bodies £'000 |
|-------------------------|--|--|
| By up to three months | 4,050 | 607 |
| By three to six months | 74 | 1,877 |
| By more than six months | 108 | (251) |
| Total | 4,232 | 2,233 |

12.3 Loss Allowance on Asset Classes

| | Trade and Other Receivables - Non DHSC Group Bodies £'000 |
|--|--|
| Balance at 1 July 2022 | - |
| Lifetime expected credit losses on trade and other receivables-Stage 2 | (26) |
| Transfer by absorption from other entity | (28) |
| Total | (54) |

13. Cash and Cash Equivalents

| | 2022-23 £'000 |
|---------------------------------|--------------------------|
| Balance at 1 July 2022 | - |
| Net change in period | 38 |
| Balance at 31 March 2023 | 38 |

Made up of:

| | |
|--|-----------|
| Cash with the Government Banking Service | 38 |
| Cash and Cash Equivalents as in Statement of Financial Position | 38 |

| | |
|---------------------------------|-----------|
| Balance at 31 March 2023 | 38 |
|---------------------------------|-----------|

14. Trade and Other Payables

| | Current 2022-23 £'000 |
|---|--------------------------------------|
| NHS payables: revenue | 29,230 |
| NHS accruals | 3,574 |
| Non-NHS and other WGA payables: revenue | 53,054 |
| Non-NHS and other WGA accruals | 216,141 |
| Social security costs | 847 |
| Tax | 807 |
| Other payables and accruals | 10,819 |
| Total Trade and Other Payables | 314,472 |

Other payables and accruals include a total pension liability of £2,841,860. This includes outstanding pension contributions for ICB employees of £932,900 as at 31 March 2023; the balance relates to GP Pension contributions.

15. Provisions

| | Current 2022-23 £'000 | Non-current 2022-23 £'000 |
|--------------------------------------|-----------------------------|---------------------------------|
| Restructuring | 3,627 | - |
| Redundancy | 320 | - |
| Continuing care | 1,814 | - |
| Other | 12,925 | 100 |
| Total | 18,686 | 100 |
| Total Current and Non-current | 18,786 | |

| | Restructuring £'000 | Redundancy £'000 | Continuing Care £'000 | Other £'000 | Total £'000 |
|---|------------------------|---------------------|-----------------------------|----------------|----------------|
| Balance at 1 July 2022 | - | - | - | - | - |
| Arising during the period | 3,627 | 320 | 217 | 1,923 | 6,087 |
| Reversed unused | - | - | (1,816) | (3,489) | (5,305) |
| Transfer from other public sector body under absorption | - | - | 3,413 | 14,591 | 18,004 |
| Balance at 31 March 2023 | 3,627 | 320 | 1,814 | 13,025 | 18,786 |
| Expected timing of cash flows | | | | | |
| Within one year | 3,627 | 320 | 1,814 | 12,925 | 18,686 |
| Between one and five years | - | - | - | 50 | 50 |
| After five years | - | - | - | 50 | 50 |
| Balance at 31 March 2023 | 3,627 | 320 | 1,814 | 13,025 | 18,786 |

Restructuring

The ICB has recognised a restructuring provision in line with IAS 37 for an organisation wide consultation which has commenced and will be completed in 2023-24.

Redundancy

The ICB recognised a £320,000 contractual redundancy provision in respect of two employees.

Continuing Care

The ICB continues to recognise a provision under IAS 37 in respect of continuing healthcare retrospective claims received for activities covering periods post 1 April 2012.

The amount carried forward represents the estimated value of outstanding restitution payments still currently under review. Cases are reviewed in line with the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care guidance.

The ICB has recognised a new provision in respect of a CHC patient for which the total care package entitlement was being disputed. The amount recognised represents the expected settlement for care costs which the family incurred themselves outside of the ICB's care package offer.

Other

The majority of this category relates to a provision for back dated rental reimbursements for a number of GP practices, £12,924,694; the balance relates to a provision for dilapidations in relation to the vacating of leased office space, £100,000.

NHS Resolution

A provision for £128,250 in respect of CNST claims is held in the accounts of NHS Resolution as at 31 March 2023; this is held on behalf of the ICB.

16. Contingencies

A contingent liability is a potential obligation that may result, but is not likely to result because the event causing the obligation is improbable.

There were no contingent liabilities in the financial period.

17. Financial instruments

17.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the ICB is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the ICB standing financial instructions and policies agreed by the Board. Treasury activity is subject to review by the ICB and internal auditors.

17.1.1 Currency Risk

The ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations. The ICB and therefore has low exposure to currency rate fluctuations.

17.1.2 Interest Rate Risk

The ICB could borrow from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The ICB has used the HM Treasury incremental borrowing rate, a fixed rate, in the measurement of lease liabilities. The ICB, therefore, has low exposure to interest rate fluctuations.

17.1.3 Credit Risk

The majority of the ICB's revenue comes from parliamentary funding, therefore, the ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

17.1.4 Liquidity Risk

The ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

17.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

17.2 Financial Assets

| | Financial Assets measured at Amortised Cost 2022-23 £'000 |
|--|--|
| Trade and other receivables with NHSE bodies | 8,701 |
| Trade and other receivables with other DHSC group bodies | 6,664 |
| Trade and other receivables with external bodies | 7,980 |
| Cash and cash equivalents | 38 |
| Total at 31 March 2023 | 23,383 |

17.3 Financial Liabilities

| | Financial Liabilities measured at Amortised Cost 2022-23 £'000 |
|---|---|
| Trade and other payables with NHSE bodies | 780 |
| Trade and other payables with other DHSC group bodies | 34,559 |
| Trade and other payables with external bodies | 287,133 |
| Total at 31 March 2023 | 322,472 |

18. Related party transactions

Employees of NHS North East London ICB are required to disclose any relevant and material interests they may have in other organisations (related parties). This is recorded in the Register of Interests.

The transactions listed below are payments made to the related parties declared by NHS North East London ICB's Board members (other than payments to practices and other NHS bodies) :

| | 2022-23 Payments to Related Party | 2022-23 Receipts from Related Party | 2022-23 Amounts owed to Related Party | 2022-23 Amounts due from Related Party |
|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| Compost London CIC | 5 | - | - | - |
| City & Hackney GP Confederation | 13,020 | 55 | 1,234 | - |
| Community Health Partnerships | 2,784 | - | 145 | - |
| Greater London Authority (GLA) | - | 183 | - | - |
| Hertfordshire Partnership University NHS Foundation Trust | 14 | - | - | - |
| London Borough of Hackney | 21,781 | 2,653 | 2,695 | 134 |
| London Borough of Havering | 12,415 | 34 | 7,394 | 148 |
| London Borough of Tower Hamlets | 11,212 | 1,723 | 7,021 | 6,813 |
| MacMillan Cancer Support | - | - | - | 5 |
| Together First Limited (GP Federation) | 1,651 | - | 138 | - |

The Department of Health and Social Care is regarded as a related party. During the period NHS North East London ICB has had a significant number of material transactions (more than £1m) with the Department, and with other entities for which the department is regarded as the parent department, and NHS England the parent entity, including:

- Barking, Havering & Redbridge University Hospitals NHS Trust
- Barts Health NHS Trust
- Chelsea And Westminster Hospital NHS Foundation Trust
- Community Health Partnerships
- East London NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Guy's & St Thomas' NHS Foundation Trust
- Health Education England
- Homerton Healthcare NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- King's College Hospital NHS Foundation Trust
- Lewisham & Greenwich NHS Trust
- London Ambulance Service NHS Trust
- London North West University Healthcare NHS Trust
- Mid and South Essex NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- NHS England
- NHS North Central London ICB
- NHS Property Services
- NHS South East London ICB
- NHS South West London ICB
- North East London NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- Royal Free London NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- St George's University Hospitals NHS Foundation Trust
- The Princess Alexandra Hospital NHS Trust
- The Whittington Health NHS Trust
- University College London Hospitals NHS Foundation Trust

During the period NHS North East London ICB has had a number of material transactions with other government departments and other central and local government bodies. The material transactions have been with:

- London Borough of Barking and Dagenham
- London Borough of Hackney
- London Borough of Havering
- London Borough of Newham
- London Borough of Redbridge
- London Borough of Tower Hamlets
- London Borough of Waltham Forest
- NHS Pensions
- HM Revenue and Customs

The transactions listed below are payments made to those practices where one of the GPs of that practice is or has been a member of NHS North East London ICB's Board during the period. These payments include GMS/PMS contract and adhoc payments, but exclude prescribing payments:

| | 2022-23 Payments to Related Party | 2022-23 Receipts from Related Party | 2022-23 Amounts owed to Related Party | 2022-23 Amounts due from Related Party |
|--|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| Aurora Medcare - Dr. Jagan John | 1,983 | - | 161 | - |
| Nightingale Practice - Dr. Mark Rickets | 1,492 | - | - | - |
| Parkview Medical Centre - Dr. Jagan John | 476 | - | 31 | - |

19. Operating Segments

The ICB considers it has only one operating segment that being commissioning of healthcare services.

20. Joint Arrangements - Interests in Joint Operations

20.1 Interests in Joint Operations

The ICB has section 75 pooled budget arrangements, transferred from the CCG, with the following local authorities - London Borough of Barking and Dagenham (from 1 April 2015), London Borough of Havering (from 1 April 2015), London Borough of Redbridge (from 1 April 2015), London Borough of Newham (from 6 November 2015), London Borough of Tower Hamlets (from 1 April 2019), London Borough of Waltham Forest (from 1 April 2019), London Borough of Hackney (from 1 April 2020) and the City of London (from 1 April 2020). All the local authorities host the pooled budgets.

In line with IFRS 11 joint control over each of the pooled funds exists, however, the members of the fund have agreed to have one lead body to commission services from providers. As a result the ICB has entered into lead commissioning arrangement whereby the risks and rewards of the contractual obligations of the pool fund budgets lay with each respective commissioner.

All financial risks and rewards appropriate to the ICB are included within the Statement of Comprehensive Net Expenditure.

The ICB's shares of the assets, liabilities, income and expenditure handled by the pooled budgets in the financial year were:

| Name of Arrangement | Other Party to the Arrangement | 2022-23 | | | |
|---------------------|--------------------------------------|-----------------|----------------------|-----------------|----------------------|
| | | Assets £'000 | Liabilities £'000 | Income £'000 | Expenditure £'000 |
| Better Care Fund | London Borough of Barking & Dagenham | - | 1,504 | - | 13,260 |
| Better Care Fund | London Borough of Havering | - | 1,993 | - | 17,027 |
| Better Care Fund | London Borough of Redbridge | - | 606 | - | 17,205 |
| Better Care Fund | London Borough of Newham | - | - | - | 20,453 |
| Better Care Fund | London Borough of Tower Hamlets | - | 2,484 | - | 23,657 |
| Better Care Fund | London Borough of Waltham Forest | - | - | - | 16,141 |
| Better Care Fund | London Borough of Hackney | - | 98 | - | 18,306 |
| Better Care Fund | City of London | - | 267 | - | 634 |

21. Losses and Special Payments

The ICB made no special payments and incurred no losses during the period.

22. Events after the End of the Reporting Period

There are no events to report after the end of the reporting period.

23. Financial Performance Targets

NHS ICBs have a number of financial duties under the Health and Care Act 2022

The ICB's performance against those duties was as follows:

| | 2022-23 Target £'000 | 2022-23 Performance £'000 | 2022-23 Achievement £'000 | Duty Achieved |
|--|----------------------------|---------------------------------|---------------------------------|------------------|
| Capital resource use does not exceed the amount specified in Directions | 464 | 464 | - | Yes |
| Revenue resource use does not exceed the amount specified in Directions | 3,186,125 | 3,186,087 | 38 | Yes |
| Revenue administration resource use does not exceed the amount specified in Directions | 33,690 | 33,473 | 217 | Yes |