NHS
North East London
Integrated Care Board

NHS North East London Integrated Care Board

26 July 2023, 1.30pm – 4.00pm; Microsoft Teams

Agenda

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	1.30	Chair		Note
1.1.	Declaration of conflicts of interest			Attached	Note
1.2.	Minutes of the meeting held on 31 May and 23 June 2023			Attached	Approve
1.3.	Matters arising			Verbal	Note
1.4.	Actions log			Attached	Note
2.0	**Resident story**	1.40		Verbal	Discuss/ note
3.0	**Chair and chief executive reports**				
3.1.	Chair's report	2.10	Chair	Attached	Note
3.2.	Chief executive officer's report	2.15	ZE	Attached	Note
4.0	**Strategy**				
4.1.	NEL System People and Workforce Strategy	2.20	FO	Attached	Approve
5.0	**Quality**				
5.1.	Deep dive: health inequalities	2.30	JM/ HR	Attached	Note
5.2.	Quality oversight and support report	2.50	DJ	Attached	Note
6.0	**Finance and performance**				
6.1.	Month 3 2023/24 financial overview	3.00	HB	Attached	Note
6.2.	Performance report	3.05	HB	Attached	Note
7.0	**Governance**				
7.1.	Governance Handbook amendments	3.15	CPo	Attached	Approve
7.2.	Board Assurance framework	3.25	CPo	Attached	Note
7.3.	Committee exception reports for information: • Executive Committee • Audit and Risk Committee • Workforce and Remuneration Committee • Quality, Safety and Improvement committee • Finance, Performance and Investment committee • Population Health and Integration committee	3.35	Chair	Attached	Note

	Item	Time	Lead	Attached/ verbal	Action required
8.0	**Board forward plan**	3.40	Chair	Attached	Discuss
9.0	**Questions from the public**	3.45	Chair	Verbal	Discuss
10.0	**Any other business and close**	4.00	Chair	Verbal	Discuss
Date of next meeting: 27 September 2023					

Purpose, priorities, aims and our decision-making principles

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

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

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

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

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

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

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

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

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

The four aims of our integrated care system

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

Our decision-making principles

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

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

NHS
North East London

North East London Integrated Care Board Register of Interests

- Declared Interests as at 23/05/2023

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

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

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

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

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

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

- Nil Interests Declared as of 23/05/2023

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

NHS
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Minutes of the NHS North East London ICB board

31 May 2023, 1.30pm – 4.00pm, Council Chambers, Havering Town Hall

Members:	
Marie Gabriel (MG)	Chair, NHS North East London and North East London Health and Care Partnership
Diane Herbert (DH)	Non-executive member, NHS North East London
Zina Etheridge (ZE)	Chief executive officer, NHS North East London
Paul Calaminus (PC)	NHS trust partner member
Cllr Maureen Worby (MW)	Local authority partner member
Henry Black (HB)	Chief finance and performance officer, NHS North East London
Paul Gilluley (PGi)	Chief medical officer, NHS North East London
Diane Jones (DJ)	Chief nursing officer, NHS North East London
Caroline Rouse (CR)	VCSE partner member
Dr Jagan John (JJ)	Primary care partner member
Dr Mark Rickets (MR)	Primary care partner member
Imelda Redmond (IR)	Non-executive member, NHS North East London
Cha Patel (CPa)	Non-executive member, NHS North East London
Attendees:	
Manisha Modhvadia (MM)	Healthwatch participant
Charlotte Pomery (CPo)	Chief participation and place officer, NHS North East London
Francesca Okosi (FO)	Chief people and culture officer, NHS North East London
Johanna Moss (JM)	Chief strategy and transformation officer, NHS North East London
Marie Price (MP)	Director of communication and involvement, NHS North East London
Russell Simberg (RS)	Involvement representative, North East London NHS Foundation Trust
Anne-Marie Keliris (AMK)	Head of governance, NHS North East London
Katie McDonald (KMc)	Governance manager, NHS North East London
Apologies:	
Shane DeGaris (SD)	NHS trust partner member
Mayor Philip Glanville (PGl)	Local authority partner member

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting including members of the public who had joined the board meeting to observe either in person or via the virtual link. The Chair advised people of the fire alarm procedure and other housekeeping matters before proceeding.
1.1	Declaration of conflicts of interest

	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the ICB. No additional conflicts were declared. Declarations declared by members of the ICB are listed on the ICB's Register of Interests. The Register is available either via the Governance Team or on the ICB's website.
1.2	Minutes of the last meeting
	The minutes of the meeting held on 29 March 2023 were agreed as a correct record.
1.3	Matters arising
	There were no matters arising.
1.4	Action log
	The Chair requested that the first two actions on the log (1.3 and 6.0) are combined into one action given that they are interlinked. The Chair advised that action 3.2 is complete and that the corporate objectives have been refined and will be circulated outside of the meeting. **ACTION:** Refined corporate objectives to be circulated to members. The ICB Board noted the actions taken since the last meeting.
2.0	**Resident story**
	RS provided members with his story as a resident of north east London which focussed on his mental health and past challenges with substance. Key points included: • A breakdown within the family unit led to RS living in poor accommodation which exacerbated health issues. • Due to a deteriorating health, the GP increased medication which included painkillers and eventually led to RS using substances as a way to manage pain, which in turn led to deteriorating mental health. • RS sought support and received treatment at the Petersfield Centre and has been working with a case worker for several years. • The centre provided psychotherapy and Cognitive Behavioural Therapy treatments so RS is now aware of his depression and stress triggers and can manage this effectively. • The centre also helped RS contact an organisation who helped to improve his housing situation. • RS is now living substance misuse free and works for North East London NHS Foundation Trust (NELFT) as a service user involvement representative. *Francesca Okosi joined the meeting at 1.40pm.* The Chair thanked RS for his openness and members raised the following points: • We need to consider how we intervene early to prevent the spiralling effect described.

	• This needs to take in to consideration RS's point that the individual needs to be open and accepting of treatment to be able to make progress. • Long waiting lists for treatment can be difficult for people experiencing challenges and, therefore it is important to recognise that support whilst waiting is needed when planning pathways. • NELFT has involvement representatives sitting on interview panels which is important as this sets the tone and culture of the organisation. • Good housing is of great importance , particularly for residents, as a haven and a base to get well from. The ICB Board thanked RS for sharing his story and noted the key points arising from the resident story. *Russell Simberg left the meeting at 1.50pm.*
3.0	**Chair and chief executive reports**
3.1	Chair's report
	MG presented the report which provided an update on the most significant activities undertaken by the Chair and non-executives since the last ICB board meeting. The following key areas were highlighted: • The Chair thanked system leaders in achieving a financially balanced operational plan, whilst staying true to our local ambition and the four aims of an integrated care system. • Members congratulated Councillor Neil Wilson who was appointed Deputy Chair of the North East London Integrated Care Partnership (ICP) and its Steering Group, which was agreed at the meeting held on 5 April. • The main focus of the meeting on 5 April was regarding co-production and it was acknowledged that using a common language would be beneficial and recognised that Voluntary, Community and Social Enterprises (VCSEs) expertise comes in many forms such as professional, educational and lived experiences. • On 11 May, non-executives from across North East London met to discuss their role in system leadership. There was shared support for a focus on prevention to secure local term sustainability, which includes a focus on root causes and a move from inpatient to community-based care. There was also an agreed position to focus on delivery, to recognise and be transparent about mutual accountability between partners and also our joint accountability to our shared population to improve. • The non-executive members and associate non-executive members have agreed to take on Lead Borough Roles, which will enable a better understanding of individual places to inform contributions. The ICB Board noted the report.
3.2	Chief executive officer's report
	ZE presented the report and noted the following key areas: • The system has started to plan for next winter and is reviewing system resilience and what more is needed to put in place a system level response. Detailed reviews will be undertaken on what is working well and which areas need additional support. A summit was held in May to discuss further with system partners. • NHS England (NHSE), has introduced a new tiering system for urgent and emergency care systems and NHS North East London has been placed in

	tier one. This is an improvement intervention rather than a regulatory intervention. • The operating plan has a balanced overall system position, however includes some organisations in significant deficit, largely in the acute provider sector, offset by surpluses elsewhere. Whilst the operating plan is balanced overall it contains an unprecedented level of financial risk and represents a significant challenge to deliver. • It was also noted that North east London has low levels of capital compared with other systems in the country, not having adequate infrastructure makes it difficult to run and improve services and this point has been shared with NHSE. • The formal consultation for the ICB restructure has been extended by two weeks to enable sufficient time to review the feedback and revise the proposals ahead of signing off the final structures. Members discussed the report, with key points including: • Local Authority leaders have agreed to write a letter to the Secretary of Health and Treasury to explain that additional financial allocations and further investment is required for North East London. • The national workforce strategy was not published as anticipated on 30 May, however, although important, this is not required in order to continue with local workforce plans. The ICB Board noted the report.
4.0	**Strategy**
4.1	Operating plan and 2023/24 ICB Budget
	HB presented the report and explained: • The system has submitted compliant targets in urgent and emergency care, cancer, people with a learning disability and autism. • The targets which are non-compliant are in community health services, elective care and diagnostics, mental health, perinatal and access to Children and Young People's (CYP) services and primary care was not compliant against dental activity. • The meeting noted and welcomed the action being taken to improve areas where we were not compliant. • The workforce submission plans for significant growth of substantive staff and reductions in bank and agency which will have benefits financially as well as in quality. • The key change to the finance plan was the movement from a system deficit of £73.1m to a breakeven position. Within the overall breakeven plan, Barts have a deficit, BHRUT and Homerton are close to breakeven and the ICB, ELFT and NELFT are all delivering a surplus to offset the deficit. • The plan includes a significant level of risk of £209.5m that is currently unmitigated. If any of the risks materialise this may impact on the delivery of the breakeven position. Additionally, there are £277.8m efficiencies built into the plan, with a risk of delivery slippage. • The Finance, Performance and Investment Committee reviewed the 2023/24 ICB budget at its meeting on 30 May and have recommended approval by the ICB board. Members discussed the operating plan and budget with key points including:

	• There is a national focus on discharge which is why there is limited reference to prevention within the report. It is expected that initial work on prevention will be funded via the ringfenced Health Inequalities Fund. • Concerns were raised regarding the contractual framework for dental services. It was explained that the framework is inherited, however if provider targets are not met then the monies can be recycled for use elsewhere. • There is potential that inflation will further increase which may crystallise deficits. The risks to delivery and mitigations should continue to be presented to the Board within the finance and performance paper going forward. • Regarding trajectories, the provider collaboratives are looking to reduce variation at place, however levelling up will need to take place in stages within the same funding envelope, rather than being able to address this all at once. • The language used within reports should be carefully considered; the term 'beds' is often used opposed to 'people'. • It would be beneficial to schedule a deep dive into community services at a future meeting. **ACTION:** Risks to delivering the operating plan to be included in the finance and performance report going forward. **ACTION**: A deep dive into community services to be scheduled for a future meeting. The ICB Board: • Noted the verbal update from the Finance, Performance and Investment Committee on the operating plan and 2023/24 budget. • **Approved** the operating plan and 2023/24 ICB budget.
4.2	Making north east London a Living Wage system
	FO presented the report and explained the following key points: • The report proposes that north east London Integrated Care System (ICS) commits to becoming a London Living Wage (LLW) system across the geography, including NHS Trusts, primary care, local authorities and social care providers. • In order to qualify for this recognition, senior leaders across the ICS must commit to working towards the aim to implement the LLW. • The commitment would support delivery of the NEL Anchor Charter priority of 'Widening access to employment, training and providing the best working experience'. All partners across the system have signed up to the Anchor Charter and providers should now convene to share learning and develop an action plan, including for the delivery of LLW. • There are significant challenges to building a sustainable approach to paying LLW across primary and social care. These sectors consist of a large number of individual employers with different organisational structures and practices, and there is no pre-existing framework such as Agenda for Change in place as it is across the NHS. The Board discussed the report with points including: • It would help to understand whether LLW is achievable in practice if we had costings included within the report.

	• It is important to support primary and social care colleagues with this commitment and acknowledge that this cannot be delivered at the same time across all employers. • It will need to be clear in communications to staff and the public that this is an aspiration for the system, but a requirement for NHS partners only. • There is a risk that smaller, local employers may inadvertently be excluded from opportunities if they cannot commit to delivering an LLW. • Further updates on this work will be provided via the Workforce and Remuneration Committee and Executive Committee exception reports to the Board. The ICB Board: • Reconfirmed their commitment, as per the NEL Anchor Charter, for the ICS to become a London Living Wage system • Supported the development of a programme of work to ensure implementation and to galvanise progress towards accreditation • Noted that oversight of the programme will be held via the NEL People Board and be linked to the emerging Workforce Strategy.
5.0	**Quality**
5.1	Deep dive: mental health and wellbeing in north east London
	PC presented the mental health and wellbeing in north east London deep dive and highlighted the following key points: • North east London has some of the highest levels of mental ill-health in the country. Four of the seven places have the very highest levels of first episode psychosis in the country, which largely occurs in young adults. Those same boroughs also have amongst the highest levels of all serious mental illness in the country. • There is growing evidence of the impact of social determinants on mental health, which the pandemic has exacerbated. In 2017, Thrive London mapped risk factors for mental health across London; risk factors included 28 indicators including domestic violence, crime and unemployment. Five of the eight highest risk areas in London are in north east London which are Barking and Dagenham, Hackney, Newham, Tower Hamlets and Waltham Forest. • North east London is one of the most diverse populations in the country, with people who have a range of different ethnicities living in our boroughs. There is a clear link between the impact of racism and mental health, for example in the fact that young black men are more likely to be admitted to hospital under the Mental Health Act or to be placed in seclusion. • People with serious mental illness die on average 15 years younger than the general population. There is a complex set of reasons, including poverty, the impact of social determinants more generally on health, and the impact of anti-psychotic drugs on weight, and higher levels of smoking in the mental health population. Over the past several years, life expectancy for people with serious mental illness has reduced further including in north east London. • The Mental Health, Learning Disability and Autism Collaborative is working with place-based partnerships to develop place-based mental health partnerships, taking responsibility for planning and delivering both place-based priorities for mental health and north east London-wide priorities for mental health in a joined up, integrated way across partners. Place-based mental health partners, as they develop, include service users and carers, health and care professionals and the voluntary sector.

	• The collaborative is also putting in place clinically led improvement networks across the seven places, where there is a priority or issue that can best be solved by working together across partners and across places. Improvement networks have been established for child and adolescent mental health, talking therapies in primary care and are developing networks for perinatal mental health, dementia and rehabilitation. Board members discussed the deep dive report and points made included: • There is a need to transition to the prevention space and to collectively take risks in doing so. This would enable a focus on wellbeing as well as diagnosis. • Communities grow friends and therefore opportunities for early intervention, however communities will need to have access to appropriate contact details to seek support from services. • There has been an exponential growth in mental health presentations within primary care, with more people experiencing loneliness, isolation and financial pressures. Further support and resilience could be achieved by taking a public health approach, including for children and young people's services. • There has also been an increase in members of staff reporting poor mental health, therefore it is important to support the wider workforce and include them in coproduction. • Housing has been a recurrent theme within the residents' stories presented to the Board, therefore it is important that the relationships built with housing services during the pandemic are revisited. • The Board noted the Metropolitan Police's announcement that officers will no longer attend 999 calls linked to mental health incidents from September, unless there is a threat to life. It was noted that further work is required so that members of the public are supported to act when someone is distressed. It was noted that a round table is being organised with the three Basic Command Unit Commanders in north east London to discuss how we work in partnership on mental health. • Interfacing being the provider collaboratives and place partnerships could be improved to ensure discussions are relevant, responses are integrated and to maintain a bottom up approach. • Access to psychological therapies is improving as there are various treatment options. There is an increase in group work happening within the digital space which allows for more people to get treatment at the same time, thereby reducing waiting times. The option to have one-to-one treatment with a professional still remains also. The ICB Board noted the report.
6.0	**Finance and Performance**
6.1	Month 12 2022-23 finance overview and draft financial statement update
	HB presented the report and noted the following key points: • The final ICS year-end reported position is a deficit of £24m. • The deficit position is driven by two system providers (Barts and BHRUT). Their combined deficit at year-end is £27.4m which has been partly offset by a reported surplus at ELFT, NELFT and Homerton, resulting in a provider year-end variance to plan of £24.1m. • The ICB has reported a very small surplus of £0.04m. • The pressures reported in prior months have continued to year-end. Providers have reported inflationary, efficiency and payroll pressures, whilst

	the ICB continues to see run rate pressures in continuing healthcare and prescribing. These have been mitigated in part using non-recurrent measures but continue to be a risk moving into 2023/24. The ICB Board noted the report.
6.2	Performance Report – February 2023 period
	HB presented the report and highlighted the following points: • Due to the national validation process, there is a delay in reporting meaning that the information provided is data from February 2023. • On 30 January 2023, a national urgent and emergency care recovery plan was published and the ICB was informed on 10 May 2023 that the system will be supported in Tier 1 (highest risk) for 2023/24. • The referral to treatment waiting list has reduced and it is expected that nobody will be waiting for longer than 18 months by June 2023, unless due to patient choice. • North east London continues to report the highest volume of patients waiting for an imaging investigation in London. The number of patients waiting over 6 weeks is greatest at Barts Health, mainly driven by waits for Non-Obstetric Ultrasound (NOUS), MRI and CT, despite improvements noted in the latest month. Members discussed the report with key points including: • Clock stop activity has seen a sharp rise; this is in line with trajectory but is likely due to validation. HB agreed to confirm and address this outside of the meeting. • NHS England's letter to ICBs regarding patient choice should not have an adverse effect on performance reporting as delays due to patient choice can be evidenced to regulators. • There is significant variation between providers in north east London in regards to ambulance handover times which the London UEC meeting has renewed focus on and is looking to move to a 45-minute handover target. Further work is required with partners to deliver this using quality improvement techniques. • Industrial action has had an impact on elective recovery performance and it is likely that further action will be taken until the end of the financial year. Various groups and sub-groups have been developed to mitigate the impacts as well as focus on recovery. **ACTION:** HB to confirm whether the sharp rise in clock stop activity was due to the validation process. The ICB Board noted the report.
7.0	**Governance**
7.1	Governance handbook amendments
	CPo presented the report and noted the following key points: • Since 30 November 2022 there have been further updates to committee Terms of Reference (ToR) which include recommendations made in a recent internal audit review on governance and risk. There has also been further work to develop the ToR of sub-committees at place which links to the mutual accountability framework. • The Barking and Dagenham Borough Partnership have developed nationally pioneering proposals to hold the ICB sub-committee and Health

	and Wellbeing Board (HWB) as committees in common from June 2023. This is innovative work as a closer alignment of the HWB and the ICB sub-committee will streamline the current governance arrangements; speed up decision making, improve alignment of actions on priorities and in doing so will improve services through greater collaboration and reduction in duplication. • Further work is ongoing on the development of joint committee arrangements of the collaboratives and an update on this will be presented to the next board meeting. The ICB Board agreed: • The proposed Barking and Dagenham committee in common arrangement. • The updated Governance Handbook.
7.2	Board Assurance Framework
	CPo presented the Board Assurance Framework (BAF) and explained: • The BAF has been refined and updated following review of the Chief Officer portfolio risk registers. The paper also includes detailed templates for the new risks agreed at the last meeting which include: o Mutual accountability for commitments o Digital and estates o Anti-racist commitment o Being outward looking • The Audit and Risk Committee also considered the BAF at their last meeting and welcomed the progress made, particularly the inclusion of digital and estates risks. Members discussed the report with key points including: • It is positive that the risks on the BAF are written with the impact to residents at its focus. • Several risks require updating as it is almost a year since the ICB was established. The Chair offered to meet with executives to discuss this further if required. **ACTION:** Chief Officers to review and update the BAF risks they are responsible for and to contact the Chair to discuss further if required. The ICB Board noted the report.
7.3	Committee exception reports for information
	The chairs/ vice-chairs of the committees of the Board each presented an exception report which highlighted the work undertaken by its members since the last meeting. The reports included updates from: • Audit and risk committee • Workforce and remuneration committee • Quality, safety and improvement committee • Finance, performance and investment committee • Population health and integration committee. The ICB Board noted the exception reports.
8.0	**Board forward plan**
	The ICB Board noted the forward plan.

9.0	Questions from the public
	The Chair welcomed the questions that had been submitted by members of the public in advance of the board meeting. Karen Smallwood asked the following question in advance of the Board meeting: **Q:** As a small charity providing support for those with moderate mental health issues, how can we work in partnership with the NHS? **A:** The ICB recognises the crucial role small charities play in the health and wellbeing of local residents. The local place-based partnership director has connected with Karen to discuss this in more detail and will provide details of the local Council for and Voluntary Service (CVS) who promote, support and develop the voluntary and community sector as well as the Voluntary, Community and Social Enterprise (VCSE) Collaborative which is being developed. Josh Mellor asked the following question ahead of the Board meeting and was in attendance to ask the Board directly: **Q:** In a number of recent enquiries I have made, which are dealt with by a member of communications staff at something called the CSU, the responses have been limited in scope and avoided acknowledging or responding to key questions in the enquiry. In some cases, the CSU staff member declines to pass on my follow up questions to their "primary care colleagues", who the CSU colleague appears to have become a gatekeeper to rather than a medium. An example of limited transparency is a request to know what commissioning decisions are being made by NHS NEL, following its decision to stop publishing primary care commissioning decisions when it transformed from a CCG to an ICB in July 2022. The reason for not providing details of primary care commissioning decisions? "We are no longer required to by law". After several slightly vague responses to requests to release this uncontentious information, regardless of NHS NEL's legal obligations, I attempted to ask through FOI. The response that came back last week did not even acknowledge two of the four (clearly numbered) questions about decisions that have been made. The first time I submitted a list of questions to ask at a public board meeting last year it was suggested I communicate via the communications team instead. But following that first meeting, in attempting to obtain the statistics behind one of the board's responses (on ratios of GP to patient in each borough), I had to go through several more exchanges with the communications team and later FOI, before the source of the figures was clarified (and even then only partially). I am optimistic about the NHS NEL's potential in the face of some very serious challenges East London healthcare has, but I am concerned that in the few enquiries that I have made the responses appear to be to spin, delay or evade rather than acknowledge and answer directly. Is this approach appropriate for an NHS body? Does this display the commitment to transparency and accountability that the NHS pledges in its constitution? **A:** We are committed to openness, accountability and transparency for the ICB, hence these board meetings are circulating around the seven place-based partnership bases. Being open, transparent and accountable are really important. The ICB and the integrated care partnership, established on 1 July last year, are not the same as the CCGs that went before. There are different responsibilities and accountabilities,

	and I am confident that we are meeting our legal and statutory responsibilities in this regard. We are not quite a year in yet, with more responsibilities and guidance coming through from our regulator. As part of our annual review we will be reflecting on a range of feedback to ensure that we adapt and develop our governance to ensure things are working well in line with our principles. This goes for all of the processes we have in place for people to contact us with their questions and feedback.
10.0	**Any other business and close**
	There were no further items for discussion.
	Date of next meeting – 23 June 2023

North East London
Integrated Care Board

Minutes of the NHS North East London ICB board

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

Members:	
Marie Gabriel (MG)	Chair, NHS North East London and North East London Health and Care Partnership
Diane Herbert (DH)	Non-executive member, NHS North East London
Zina Etheridge (ZE)	Chief executive officer, NHS North East London
Paul Calaminus (PC)	NHS trust partner member
Cllr Maureen Worby (MW)	Local authority partner member
Henry Black (HB)	Chief finance and performance officer, NHS North East London
Paul Gilluley (PGi)	Chief medical officer, NHS North East London
Dr Jagan John (JJ)	Primary care partner member
Dr Mark Rickets (MR)	Primary care partner member
Imelda Redmond (IR)	Non-executive member, NHS North East London
Cha Patel (CPa)	Non-executive member, NHS North East London
Attendees:	
Charlotte Pomery (CPo)	Chief participation and place officer, NHS North East London
Francesca Okosi (FO)	Chief people and culture officer, NHS North East London
Johanna Moss (JM)	Chief strategy and transformation officer, NHS North East London
Marie Price (MP)	Director of communication and involvement, NHS North East London
Anne-Marie Keliris (AMK)	Head of governance, NHS North East London
Katie McDonald (KMc)	Governance manager, NHS North East London
Apologies:	
Shane DeGaris (SD)	NHS trust partner member
Mayor Philip Glanville (PGI)	Local authority partner member
Caroline Rouse (CR)	VCSE partner member
Diane Jones (DJ)	Chief nursing officer, NHS North East London
Manisha Modhvadia (MM)	Healthwatch participant
Andrew Blake-Herbert (ABH)	Local authority participant
Colin Ansell (CA)	Local authority participant

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting including members of the public who had joined the board meeting to observe.
1.1	Declaration of conflicts of interest
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the ICB. Dr Mark Rickets declared a financial interest in the Nightingale Practice which receives payments from the ICB as indicated in the annual report and accounts. MR advised that he is a salaried GP at this practice, not a partner, and therefore does not receive these payments directly.

	Cha Patel declared a financial interest in Community Health Partnerships which receives material transactions from the ICB, as stipulated in the annual accounts. The Chair decided that MR and CPa could remain in the meeting. Declarations declared by members of the ICB are listed on the ICB's Register of Interests. The Register is available either via the Governance Team or on the ICB's website.
2.0	**Annual report and annual accounts - CCG Q1 and NHS North East London - Q2 to Q4 2022/23**
	CPo presented the CCG and ICB annual reports and highlighted: • There are two annual reports to approve for submission to NHS England; one for the NHS North East London CCG from April to June 2022 and one for NHS North East London ICB from July 2022 to March 2023. • The two reports were considered by the Audit and Risk Committee on 24 April and 22 June 2023 and were updated following feedback from the committee, the recent external audit and NHS England. • The reports follow the national format required and the ICB report includes additional elements with regard to new statutory duties such as safeguarding children. • Minor amendments being made to the reports following feedback which includes adding a paragraph regarding urgent and emergency care performance, updating the wording in relation to corporate objectives and some adjustments to the Human Resources tables. This will be actioned ahead of submission to NHS England. • A final version of the reports, incorporating a foreword from the Chair and a shorter user-friendly summary document will be produced and presented at September meeting, published and shared with stakeholders and local residents. • The reports have demonstrated that there is a lot to be proud of given the ICB was only established in July. Significant work was undertaken to manage the transition from CCG to ICB, ensuring a safe transfer of functions and then in establishing the new organisation. The reports also highlight examples of the partnership working at every level across north east London and demonstrate how this work is having a positive impact on local people. • The ICB annual report also sets out the priorities and challenges, including creating a resilient system year-round, particularly in regard to urgent and emergency care. • CPo thanked those involved in producing the reports including governance and communications teams, ICB and system staff and partners and the Director of Communication and Involvement. HB presented the CCG and ICB annual accounts and explained: • On 22 June 2023 the Audit and Risk Committee ratified the annual accounts and have recommended them for approval by the ICB board. At the committee, internal and external auditors provided positive feedback. • The ISA 260 letter from external auditors, KPMG, provided a full unqualified opinion with no weakness in the controls environment. • The CCG and ICB met their statutory duty to both breakeven and to contain management costs within their running cost allowances. • One minor comment was made by auditors regarding the CCG's treatment of the Elective Recovery Fund in Q1, however as this was not the end of the financial year an estimate of delivery had to be provided and this was

	adjusted by Q4, after the disestablishment of the CCG. Auditors agreed that this was the correct and appropriate treatment. • The ICB is the legal successor of the CCG and thereby inherited the assets and liabilities of the CCG, meaning it is appropriate for the ICB to approve the CCG's annual report and accounts. • HB thanked colleagues in the finance team for their hard work in producing two sets of annual accounts within one financial year. CPa, as Chair of the Audit and Risk Committee, made the following comments: • It was pleasing to have two sets of clear accounts which both internal and external auditors were happy with. • It was helpful that auditors recognised the pressures the ICB is facing from NHS England and acknowledged the level of risk this poses to the organisation. • There were no other matters that the Board should be made aware of prior to making their decision. ICB board members discussed the annual reports and accounts with key points including: • It has been beneficial to have the opportunity to reflect on the past year, which is the first as an ICB and to acknowledge the extensive work that has been undertaken already. • It would be beneficial for members to receive a copy of the final external audit opinion. • A letter of thanks should be issued to finance and audit teams. • It was acknowledged that this would be MP's last meeting prior to starting a new role at an NHS Trust. The board thanked MP for all her work at the ICB and its predecessor organisations. **ACTION:** The final external audit opinion to be circulated to members once available. **ACTION:** A letter of thanks to be given to finance and audit teams in relation to their work in producing the annual accounts. The ICB board: • Approved the annual reports and annual accounts (legacy CCG and ICB) • Agreed 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.
3.0	**Questions from the public**
	There were no questions received from members of the public.
4.0	**Any other business and close**
	There were no further items for discussion.
	Date of next meeting – 26 July 2023

North East London
Integrated Care Board

ICB board – action log

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
1.3 Action log	25 Jan 2023	Chair of the Quality, Safety and Improvement Committee to share a first draft of what the format for a future quality report should be with the board chair to ensure the content meets the requirements of the board. This will include information on the constitutional standards featured within the performance report to achieve the right balance	IR/ DJ/ HB	July 23	Complete. Agenda item scheduled for July meeting.
4.2 Financial strategy	29 Mar 2023	Henry Black to arrange a system workshop to develop shared financial understanding of each sector.	HB	Sep 23	In progress. As work on the financial strategy progresses, plans for a system workshop will be worked through.
8.0 Finance and performance overview	29 Mar 2023	Henry Black and the Chair to discuss contract variation further outside of the meeting.	HB/ MG	Sep 23	A further update to the Scheme of Reservation and Delegation SoRD will be presented at the September meeting to include primary care contracting and commissioning functions.
8.0 Finance and performance overview	29 Mar 2023	The recommendation to approve the delegation of authority for the signing of contracts and contract variations to the Chief Finance and Performance Officer and one other chief executive to be included as part of the Governance Handbook review.	HB/ CPo	Sep 23	As above - a report on the proposed changes to the Scheme of Reservation and Delegation will be presented to the Board in September.
1.4 Action log	31 May 2023	A copy of the refined corporate objectives to be circulated to members.	ZE/ MG	July 23	Complete. The corporate objectives are listed in the Board Assurance Framework report and were circulated

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
					separately to members on 23 June.
4.1 Operating plan and 2023/24 ICB Budget	31 May 2023	Risks to delivering the operating plan to be included in the finance and performance report going forward.	HB	July 23	Complete.
4.1 Operating plan and 2023/24 ICB Budget	31 May 2023	A deep dive into community services to be added to the Board forward plan for a future meeting.	MG	March 24	Agenda item scheduled for March 2024 meeting
6.2 Performance Report – February 2023 period	31 May 2023	Henry Black to confirm whether the sharp rise in clock stop activity was due to the validation process.	HB	July 23	Complete. The change in clock stop numbers was due to a range of factors, including validation. After review, it has been decided that presenting the data as a comparison against activity trends would be more meaningful, and that has been implemented.
7.2 Board Assurance Framework	31 May 2023	Chief Officers to review and update the BAF risks they are responsible for and to contact the Chair to discuss further if required.	ICB Chief Officers	July 23	Complete. Corporate risk register and BAF presented to the ICB's Executive Management Team on 3 July and risk champions have updated risks accordingly.
2.0 Annual report and annual accounts	23 June 2023	The final external audit opinion to be circulated to members once available.	HB	Sept 23	The final annual report and accounts will be presented to the Board in September.
2.0 Annual report and annual accounts	23 June 2023	A letter of thanks to be given to finance and audit teams in relation to their work in producing the annual accounts.	MG	July 23	Completed.

CLOSED ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
3.2 Chief executive officer's report	29 Mar 2023	The Chair and Zina Etheridge to discuss the corporate objectives further and consider reference to local residents and the operating plan.	MG/ ZE	May 23	Complete.
6.0 Pharmacy, optometry and dentistry services delegation programme	29 Mar 2023	Audit and Risk Committee to report to the Board regarding any implications of the POD services within its future exception reports.	CPa	May 23	Audit and Risk Committee Chair will report by exception as appropriate.
6.0 Finance and performance overview	25 Jan 2023	Further discussion to take place outside of the meeting on what would need to be included in a quality report to the board going forward and the constitutional standards information that needs to be included in the performance report in order to achieve the right balance.	HB/ DJ	July 23	Action merged with "1.3 Action log" following discussion at the Board meeting on 31.05.23

North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	Chair's Report
Author	Marie Gabriel
Presented by	Marie Gabriel, Chair
Contact for further information	Marie Gabriel, Chair Marie.gabriel1@nhs.net
Executive summary	• Key issues: This paper is focused on outcomes from meetings of the North East London Integrated Care Partnership (ICP) and the North East London Non-Executive community. The Board is asked to consider these outcomes to inform our conversations at our meeting. • The Report considers national priorities and comments on renewed focus following the Chair's appraisal. • Recommendation: To receive and note the report
Action required	For noting
Previous reporting	North East London Integrated Care Partnership meeting on 6 July North East London Chair and Non-Executive Member Meeting on 29 June
Next steps/ onward reporting	• ICP Steering Group to consider the ICP's membership and make recommendations.
Conflicts of interest	None
Strategic fit	The Big Conversation will enable us to develop success measures • To improve outcomes in population health • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The focus of Non-Executives on how different parts of the system align and integrate their work will increase the likelihood of a positive impact.
Impact on finance, performance and quality	The wider partnership's encouragement to focus on tangible delivery will support improvement in quality, finance and performance.
Risks	We are mitigating the risk by ensuring we are aware of and informing national priorities, and by working with partners and communities to deepen collaboration.

1.0 Introduction

1.1 This month is the 75th birthday of the NHS and also the first birthday of NHS North East London and I take this opportunity to thank all colleagues for their determination to work together and with the people of North East London to achieve meaningful improvements in health, wellbeing and equity. Birthdays are a real reason to celebrate and they are also a time for reflection on what more we have to do. This has happened nationally with a flurry of reports, including the NHS@75 Report and also as an Integrated Care System (ICS) as we pulled together our annual report and accounts. I thank both the governance and finance teams for all their hard work in producing our account.

1.2 The report informs the Board of the key points arising from the North East London Integrated Care Partnership and the North East London Trust Chair and ICB Non-Executive meetings to ensure their views are taken into account in Board decision making. It also reflects on national announcements and considers my Chair priorities for next year, following my appraisal.

2.0 Integrated Care Partnership

2.1 The North East London Integrated Care Partnership met in person for the first time on 6 July. Those present agreed that the opportunity to meet and hold discussions with colleagues' face to face was of benefit and asked that more meetings be held in person. At the meeting, partners reflected on early feedback from the Big Conversation with local people and communities and considered how it might shape our success measures. In summary, the meeting reached several key conclusions about how partners would define ICS success and what a success measure for kindness and compassion could look like.

- Our success measures should focus on improving people's lives not just services and both qualitative and quantitative, there is some work being undertaken at place that could support this, for example, in City and Hackney.
- Success measures should focus on the wider determinants of health and whilst recognising that tackling health inequalities requires a longer-term indicator; it would be useful to break that success measure down into stages.
- The success measures should support us working in a much more relational way and one of the ways to measure empathy was to focus on pre and post health and care intervention support, bringing in the contribution of the voluntary sector.
- In addition to success measures, we also need to ensure that we build in learning from each other, including with joint training and development across partners.
- There needs to be a success measure for integration as a result, one that helps us to build structures around people rather than squeezing people into our structures.
- That we should build on established ways to measure experiences given that a key definition of success was kindness and compassion.
- There are established measures we should consider, for example the use of 'What Matters to Me' by clinicians to support a different power dynamic. This means people will have more control, as those who use services co-create their pathway of care.
- In setting the success measures, the meeting reconfirmed that feedback and testing was also very important, to maintain dialogue and interest.
- That as the Big Conversation is the first stage in a long and deep dialogue, it should also be a learning experience. The meeting began to identify additional ways of gaining insight, such as street surveys and the need to reach out to communities,

including migrants arriving to live in the area. It was agreed that the ICB, in conversation with Healthwatch and the Voluntary, Community and Social Enterprise Collaborative, would consider how to evaluate the Big Conversation.

2.2 The meeting reflected on its membership following a request from the North East London Health and Social Care Providers Forum to join. The meeting responded positively to this request and also considered which other partners should be in the room, with housing, police, ambulance and fire service as the recommendations. The ICP Steering Group will consider these recommendations.

3.0 Chair and Non-Executive Activities

3.1 On 29 June, North East London Chairs and Non-Executive Members met to discuss the progress of our Provider Collaboratives and how they are operating at place. Key points arising from the discussion were -

- There are strong examples of progress that we should build upon and shared learning, both in terms of governance with joint committees and outcomes in terms of improved discharge.
- The collaboratives are developing and working through their operation with the ICS outcomes as they begin to deliver. This includes developing different types of support from the ICB as it restructures.
- That consideration should be given to undertaking some organisational development as a whole system now we have had a year of operation and to support the deepening of collaboration.
- The need to be confident in how we can use budgets to do things differently and the need to understand how we can implement and share learning across the system.
- It was important to now focus on the relationship between different collaboratives, between places and between collaboratives and place.
- System wide action bringing different parts together to improve is also important and be seen in action with the Urgent and Emergency Care programme. This and other examples illustrate the importance of shared values and shared purpose and also how recognising tensions can be energising in finding solutions.
- Effective communication is, of course, critical and the ICB has agreed to consider how communication flows are happening between the different elements that comprise our system.

3.2 I attended the NHS Confederation Expo Conference last month, an annual event organised jointly by NHS England and NHS Confederation. The event is always attended by both the Secretary of State and the Shadow Secretary of State as well as the Chief Executive of NHS England. There is usually an announcement that occurs, shortly before, during or just after, this time it was the NHS Mandate, HM Government response to the Hewitt Review and to Parliament's Health and Social Care Committee, NHS@75 Priorities for the Future and more recently the NHS Workforce Plan. There were similar key themes that could be pulled out of all three speeches.

- A recognition that there has been much achieved over the last 75 years and actually, quite a lot achieved in the last year. Amanda Pritchard focused particularly on the last year and the progress the NHS had made against her four key 2022/23 priorities of Recovery, Reform, Resilience and Respect. Indeed, all

three speakers were able to provide evidence of progress, for example how the NHS has been able to virtually eliminate elective waits of over two years and how we have improved lung cancer checks so that we are increasingly identifying stage one and stage two in our most deprived communities. Improvement in access to GP appointments were also identified. For all though, continuing to improve fast access to the right care remained a priority, although there was also an emphasis, sometimes not directly, on the quality of care.

- The importance of Integrated Care Systems to the future of the NHS, so that care is closer to home, health inequalities can be effectively tackled and prevention becoming a key part of care, was also a shared goal. All spoke to a different relationship with Integrated Care Systems, with fewer targets from the centre, devolved decision making and greater trust, in return for improved delivery and increased productivity.
- Increasing the effectiveness and use of technology was common throughout, with slightly different emphasis on approach. It was clear that all wanted a better use of technology, artificial intelligence (AI) and access to data, resulting in quicker diagnosis and improved patient outcomes. The opportunity to use technology and AI to release time for staff to care because of improved data, interoperability and AI that could carry out swifter and accurate diagnosis was also highlighted.
- There was a focus on workforce, the need for and commitment to create more but also the need to think differently about the skills, talents and roles that are needed as we integrate care and improve outcomes. There were references to recruiting locally, harnessing the public support seen during Covid-19 along with the need to focus on retention.
- Finally, a desire to seize innovation potential, building on a history of doing so and advances such as genomics was referred to by all three speakers.

3.3 The type of NHS leadership we will need as we move forward, and the leadership development they will need to support them, has been a common feature of my national meetings over the last few months. This includes being part of a national NHS England Management and Leadership Advisory Group and also participating in a workshop to support leadership for improvement. There appears to be a firming up of a different ask of leaders. There is still a focus on compassionate and inclusive leadership but this now comes with a greater focus on accountability for achieving improvement as seen with the NHS Equality and Diversity Plan and on operational grip, along with the ability to harness the potential of digital, technology and innovation. These have always been a requirement of leaders, but there is an emerging change in emphasis.

3.4 Finally, but importantly, I would like to thank all those who fed into my appraisal. Thank you for your kind words but also your challenge. As I look forward to our next year, it is clear that I should retain my focus on relationships and our agreed ambition to be delivered through our partnership. From your feedback, it was good to see that we are agreed that we have established governance structures effectively, although we still need to keep an eye on potential duplication; now we need to ensure that they begin to produce the right outcomes for our local people.

3.5 In this coming year, I have set myself three priorities:

- I intend to retain one of my priorities from last year, which is to meaningfully work with local people and communities to define our success measures, but with the clarity that ‘people’ includes our staff and that defining includes delivery. This I would like to take to the next stage so that we have further clarity on our clinical

strategy and system commissioning intentions, to aid discussion at Board and in committees.

- My second priority is delivery of improvement. Last year the ICB team produced an excellent Integrated Care Strategy and Joint Forward Plan, this year I would like to see us working with partners to agree one element within each of our flagship priorities where we want to improve. A priority that is meaningful to our people and communities and can illustrate what working well as a system improves and for which we can be held to account. For the whole system, I would like us to move measurably forward on our commitment to be an anti-racist ICS and in establishing our joint improvement approach.

- Finally, although I believe we have made a really good start, I would like us to focus on establishing mechanisms that ensure integrated working between provider collaboratives and between provider collaborates and place-based partnerships. This includes collaboration across partnerships to improve access and reduce unwarranted variation.

4.0 Recommendation

4.1 The Board is asked to receive and note the report

Marie Gabriel – Chair
03/07/2023

NHS
North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

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

1.0 Introduction

1.1 The last period has seen both the NHS's 75th birthday and the end of the first year of the ICB and whilst celebrations across the system have largely focussed on the first, our Big Conversation events have been a good moment to reflect on where we are and where we need to get to. It has been another highly pressured period with high levels of demand for mental health services, a number of events that have increased pressure on urgent and emergency care (UEC), such as the heatwave, and ongoing industrial action. I have also been working on finalising the ICB restructure. There have been a number of other areas of focus too including: managing pressures across UEC and mental health, the next steps on our ICB restructure as well representing north east London at both a regional and national level.

2.0 Urgent and Emergency Care pressures

2.1 System leaders and teams have been working together to manage ongoing pressures in urgent and emergency care. Several events caused pressure points such as the heat wave and 'pollen bomb' and we are seeing ongoing high levels of demand for mental health services. This in turn is reducing the speed with which people move through our system and leading to pressure in our emergency departments. We have convened several system wide meetings to ensure we have the right plans in place to ensure that those presenting in mental health crisis, wherever they present, get the care they need as quickly as possible. We have also put in place a new monthly meeting with health and local authority colleagues with local police Borough Commanders to build our partnership working and ensure that the proposed changes set out by Met Commissioner Sir Mark Rowley do not adversely impact on local people. We now have a plan on a page for the actions being taken to ensure that there is good, timely support for those in crisis including where they present at emergency departments. We are working, through the mental health and learning disabilities collaborative, on a range of actions resulting from our first round table with Borough commanders including looking at the extension of street triage, training for police officers and better shared data.

More widely, our UEC programme is the single point of focus for our improvement work, responding to all regionally and nationally mandated plans and assurance including national tier one reporting, national UEC recovery plan and any nationally mandated winter plan. The ambition is to improve access to urgent and emergency care for local people, ensuring it meets their needs and is aligned to the UEC national plan. In the short term this is about stabilising the provision of safe and accessible care over winter. In the longer term it is about sustaining a UEC system that is focused on keeping people well, meeting the health needs of the population and ensuring easy access to care where required in the community – with efficient flow through acute care when required, supported by a workforce that operates without being overwhelmed.

3.0 Industrial action and pay offer.

We continue to work as a system to manage the pressures of industrial action, most recently from five days of strikes by junior doctors followed by two days strikes by consultants. Further action by consultants has been announced for August. We will continue to do what we can to manage the impact on services and ensure patients are able to receive the treatment they need but the ongoing action has resulted in a significant number of cancellations of planned care and a substantial opportunity cost as many leaders and managers across the system have had to move their focus from transformation and improving productivity, services and efficiency to planning for industrial action on a regular basis.

4.0 Specialised services

4.1 In April 2024 specialised services are being delegated to ICBs from NHS England. Specialised services are a diverse portfolio of c150 services generally accessed by people living with rare or complex conditions. These include services for people with physical health needs, such as cancer, neurological, and genetic. Some mental health services are also 'specialised' (but are covered under a separate delegation regime). Specialised services deliver cutting edge care informed by latest

developments in medical innovation and are correspondingly costly. While often treating relatively rare conditions, collectively the specialised services portfolio collectively delivers care to large numbers of people.

The rationale for delegation is to join up local transformation initiatives and create end to end pathways of care that focus on early intervention, reducing health inequalities and improving outcomes for the population. Delegation presents both opportunities and risks. Understanding our patient and financial flows is important in shaping the local operating model and core network of stakeholders. The NHS England Board previously approved plans to jointly commission some specialised services with ICBs from 1 April 2023. NHS England and ICBs formed statutory joint committees to oversee and take commissioning decisions on 59 specialised services which coincided with the introduction of population-based budgets for these services from April 23. This was formally approved by the NHS NEL integrated care board in March 2023.

In preparation for the next stage, work is underway to ensure we are prepared for these new responsibilities through alignment and integration with the ICS integrated Care strategy, Joint Forward Plan and Acute Provider Collaborative as a delivery vehicle. Each ICB must demonstrate a robust understanding of its health and care geography and multi ICB flows of activity, governance and leadership, finance, transformation to benefit population health outcomes, workforce capacity and capability, and a grip of data, analytics and reporting. NHS North East London is working through these criteria and ensuring everything is in place for the submission at the end of August.

5.0 ICB restructure

The consultation on our staff restructure closed on 16 June. Since then we have been working through all the feedback and key themes and finalising the structures ahead of issuing the final outcomes document and individual letters to staff which we anticipate being in week commencing 17 July. Our new structure aims to enable us to continue to deliver those responsibilities we inherited from the Clinical Commissioning Group (CCG) whilst placing us in the best position to effectively deliver the ICB's responsibilities and effectively support the ICS to deliver its vision, purpose and strategy. I am grateful to colleagues in the ICB for participating so constructively in the engagement process and to partners for working with us to support and further refine our proposals.

6.0 Workforce strategy

The first comprehensive long-term workforce plan for the NHS was published in June. It covers a 15-year assessment of the workforce that will be needed for the future and provides a costed plan of how to develop the current NHS workforce to meet the future challenges. Its aim is to ensure that the NHS workforce is sustainable and able to improve patient care. It has a focus on retaining existing talent and making the best use of new technology alongside the biggest recruitment drive in health service history. It outlines that current NHS vacancies stand at 112,000 and, based on the plan's modelling, vacancies would rise to an estimated 360,000 by 2037 if no action is taken.

The plan sets out three priority areas:

1. Train – substantially growing the number of doctors, nurses, allied health professionals and support staff, which is underpinned by a £2.4bn funding commitment.
2. Retain – renewing the focus on a major drive on retention, with better opportunities for career development, improved flexible working options and continuing to improve the culture and leadership across NHS organisations. This includes reforms to the pension scheme to keep 130,000 staff working in the NHS for longer.
3. Reform – working differently and delivering training in new ways and improving productivity by building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment and provides the care patients need more effectively and efficiently.

We are currently engaging on the North East London system workforce plan and welcome this clarity from a national level. We are now working through the detail in line with finalising the next steps of our system wide approach.

NHS Mandate
In June the NHS Mandate was published. This sets out the key objectives for the NHS to deliver during the current year. There are three core priorities:

1. Cutting NHS waiting lists and recovering performance
2. Supporting the workforce through training, retention and modernising the way staff work
3. Delivering recovery through the use of data and technology

The Mandate also provides detail of the Government's expectation that the ambitions of the NHS Long Term Plan are delivered in the areas of maternity and neonatal health, mental health, learning disabilities and autism, the shift to community care, preventing ill-health and tackling health inequalities, developing a major conditions strategy and implementing the Accessible Information Standard when published. The mandate also sets out three financial tests:

1. The NHS will deliver overall revenue and capital financial balance every year.
2. NHS England will ensure that all ICBs aim to deliver financial balance. Where deficits occur, an agreed recovery plan will be in place to return to financial balance over time.
3. The NHS should make cash-releasing efficiency savings of at least 2.2% in 2023 to 2024. Productivity to continue to pre-COVID-19 levels consistent with recovery plans. Ongoing productivity improvement is integral to workforce planning.

7.0 NHS 75

7.1 A number of staff from the ICB and across the system took part in celebrations to mark 75 years of the NHS on 5 July. Staff represented north east London at a celebration service at Westminster Abbey attended by the Prime Minister, members of the Royal family and other dignitaries. Two members of staff from NELFT and Homerton attended a reception at 10 Downing Street which thanked staff for their service.

NHS Assembly report - Ahead of the NHS's 75th birthday, the NHS Assembly has developed an independent report: The NHS in England at 75: priorities for the future. This is aimed at helping the NHS, nationally and locally, respond to long term opportunities and challenges. In May, Marie Gabriel convened a group of staff from across the system to contribute to this. The group shared their insights on things we should celebrate and strengthen as the NHS approaches 75 such as the fact it is free at the point of access, the principles have remained the same and how resilient the NHS is. There was also a discussion about areas they felt the NHS is making most progress in including innovation and research, integrated working, diversity and inclusion and patient involvement in shaping services. The group also discussed where there is room for improvement looking at areas such as workforce and more focus on prevention. The Assembly found a growing consensus that the NHS should now focus on three key areas for long term development:

- better preventing ill health
- personalising care
- delivering more co-ordinated care closer to home.

8.0 Working with our partners

8.1 Big conversation

The first big conversation events took place in June and July with local residents joining the team to discuss what was important to them about health care and wellbeing, with a focus on the four system priorities. The main themes emerging from the discussions so far have been:

- People want more empathy and compassion from health and care staff
- People don't feel that agencies/organisations are working well together and don't know where they can go to get help/answers
- Need ways to support people to be physically and mentally well in local communities
- Navigating ways into health and care jobs is complicated and complex – not sure where to start/being put off

More information on how to take part can be found here.

8.2 Joint health overview and scrutiny committee (JHOSC) meetings

The latest meeting of the inner NEL JHOSC took place on 12 July. We had a productive discussion with local authority councillors about the development of our mental health, learning disabilities and autism collaborative and our community collaborative. The agenda also covered a health update on the acute trusts, the NEL big conversation, finances, the operating plan and industrial action; and an item on four new continuing healthcare policies. I look forward to meeting the outer NEL JHOSC on 27 July with a very similar agenda.

9.0 System visits and events

9.1 Dental visit – I visited the Newham Family dental practice in July to better understand dental functions, meet staff and hear first hand about the pressures, challenges and successes of the current approach. NEL ICB has taken on delegated responsibility for dental functions from NHS England and having spent some time

talking to the practice, and dental commissioning team I am really excited about the opportunities for us to do more on prevention, talking inequalities and taking a more population health approach overall.

9.2 **AHP conference** – I joined the north east London allied health professionals (AHP) conference in June to talk about our work, the integrated care partnership strategy and the opportunities of working across the integrated care system. AHPs constitute a really varied field – from art and occupational therapists to radiographers and theatre technicians and because of the roles they play are a really important part of our system development. They are often the people working closely with our residents to understand what they want to achieve and how best to support them to do this, so their ways of working go to the core of our aim to co-produce services with people, be led by the priorities of local people and build on the assets they and their communities already have.

9.3 **NEL safeguarding conference** – this took place in June and brought together safeguarding professionals across the system. The safeguarding team play a really important role in safeguarding children and vulnerable adults both through ensuring individual work happens when needed, but also by providing an important part of the 'glue' that sticks our system together. The conference was a great opportunity to hear about the work they are doing and further strengthen the system approach to working which is so vital to the way safeguarding operates.

10.0 System appointment news

10.1 Congratulations to Paul Calaminus who has been appointed as the chief executive for NELFT, starting his new role in the autumn. I would also like to congratulate Lorraine Sunduza who has been appointed interim chief executive at ELFT and look forward to working with both in their new roles. I am delighted that in Barking and Dagenham Fiona Taylor was appointed as permanent Chief Executive in May.

Zina Etheridge
July 2023

North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	NEL System People and Workforce Strategy
Author	Susan Nwanze, Interim Director of OD and Education
Presented by	Francesca Okosi, Chief People and Culture Officer
Contact for further information	Susan Nwanze: susan.nwanze@nhs.net
Executive summary	Our health and social care workforce have been facing relentless pressures since the Covid-19 pandemic which have been exacerbated by persistent workforce supply shortages in critical service delivery areas. This has an adverse effect on our ability to provide best outcomes for our NEL residents. The four system priorities of the Integrated Care Strategy include a shift towards out of hospital care in neighbourhoods and communities, as well as the provision of meaningful work and employment opportunities for people in North East London (NEL). These key drivers call for a fundamentally different workforce model across health and social care in NEL. Our NEL population is the most diverse in the country. The rich diversity of our NEL local communities places a premium to ensure that addressing inequalities, promoting diversity and inclusion, and enabling anti-racist organisations across NEL health and social care are central to our workforce model and people solutions. To bring about long-term, sustainable change, we are joining together with our NEL system partners across health and social care, including local authorities, trusts, our acute provider collaborative, our mental health and community collaboratives, primary care, independent care sector, voluntary sector and education providers, to co-design and develop an integrated, innovative and transformational NEL-wide People and Workforce strategy together with a detailed five-year delivery plan. Our significant engagement across the sector thus far, has resulted in seven high-level people and workforce strategic priorities (7Ps). As we progress towards the detailed planning phase, we will be further engaging with our ICB and ICS staff across health and social care, as well as with a wide representation of our NEL residents to get their voice and input into our People and Workforce Strategy and action plans. We will be setting up Task and Finish Groups from across the system to develop short, medium term and long-term delivery action plans specifying key performance indicators and outcome measures.

	We will also provide a governance framework for delivery of the strategy at ICB, Place, Neighbourhood and in our Collaboratives.
Action / recommendation	The Board is asked to approve the high-level strategic priorities and to endorse the next steps.
Previous reporting	ICB Executive Management Team (EMT) and the Executive Committee. This report is being discussed at the Workforce and Remuneration Committee on 25 July 2023. Verbal feedback will be shared at the Board meeting.
Next steps/ onward reporting	NEL People Board
Conflicts of interest	There are no conflicts of interests to manage
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	It would help to give our local populations access to the care that they need at neighbourhood and place and will contribute to the wider determinants of health by creating inclusive opportunities for local people across all demographic indices to have easy access to meaningful employment and flexible career options. An equalities impact assessment will be undertaken as part of the development of detailed five-year action plans.
Impact on finance, performance and quality	At this stage there are no immediate financial implications but there will be financial implications to do with the implementation of the five-year action plan once signed off.
Risks	There is a lack of dedicated workforce transformation funding in 2023/24 to meet the growing expectation of ICB funding support for workforce transformation programmes across the system.

1.0 Introduction

1.1 Our workforce is our greatest and most valuable resource. Across both health and social care, our workforce has been facing relentless pressures since the Covid-19 pandemic. Demand has outstripped capacity, largely driven by unprecedented workforce shortages and supply issues in critical health and social care roles, such as band 5-7 nurses, social workers, occupational therapists, to mention just a few. These supply shortages have led to a continuing reliance on high cost bank and agency resources as well as international recruitment to fill gaps. High turnover and low retention rates together with a burnt-out, struggling and low morale workforce directly impacts our ability to provide the best outcomes for our North East London (NEL) residents and diverse populations.

For this to change on a long-term, sustainable basis, it has become clear that in order to meet the accumulating demand from our growing and increasingly diverse NEL populations over the next five years and beyond, we need significant workforce transformation in roles and ways of working across the system, together with a new and different approach to how we plan for, attract, develop, deploy, care for and retain our health and social care workforce. It is a well-known fact that 'cared for staff provide the best care.'

In keeping with the principles of the newly released National NHS Workforce Plan (see Summary in Appendix 1) we have set about to find locally-relevant solutions that provide best outcomes for our NEL health and social care workforce and our NEL populations through the development of a pioneering NEL system-wide, integrated and innovative, People and Workforce Strategy.

We are working together with our NEL system partners across health and social care, including local authorities, trusts, our acute provider collaborative, our mental health and community collaboratives, primary care, independent care sector, voluntary sector and education providers, to co-design the People and Workforce Strategy with a detailed five-year delivery plan.

The strategy seeks to develop and enable the embedding of a joint, integrated 'one workforce' model across NEL health and social care that will pool NEL talent together to work in a new and flexible way across traditional boundaries, driven by the need to:

- Improve the health and well-being of our NEL populations in their local communities in keeping with our ICB priorities
- Equip, develop, care for and support the health and well-being and inclusion of our existing NEL health and social care workforce to enable them to positively serve our residents in their communities
- Engage, attract and develop our potential and future workforce from young people and under-represented groups in our diverse communities to give them meaningful employment opportunities.
- Address inequalities and promote anti-racist outcomes

These key drivers have informed the development of the first NEL system-wide People and Workforce Strategy to enable the creation, supply, retention and sustainability of a transformational 'one workforce' across health and social care in NEL, to meet the needs of our residents and diverse communities. Our engagement with health and social care partners across the system has resulted in the development of high-level strategic priorities. The purpose of this report is to inform the Board about how we have done this, what our key themes and high-level strategic priorities are, and what we will do next.

1.2 The Board is asked to approve the high-level strategic priorities and next steps.

1.3 We have approached the development of the people and workforce strategy in two phases. Phase 1 has focused on *what* our focus needs to be, through the setting out of high-level strategic priorities. Phase 2 will focus on *how* these priorities will be enabled and delivered through the development of detailed short, medium and long-term strategy action plans. Phase 2 is expected to be completed in the autumn.

1.4 The paper relates to the ICS vision and priorities and the ICB's collaborative leadership role across the health and care partnership. The People and Workforce Strategy will directly support the four system priorities of the Integrated Care Strategy which focuses on:

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

2.0 Key messages

2.1 Our wide engagement with our NEL system health and social care partners and key stakeholders has resulted in the following high-level strategic priorities, which are summarised below under these seven headings (7P's):

1. **Parity** – focuses on how we can achieve better equity in pay and benefits between health and social care employment terms and conditions. This would help to promote seamless joint working and retention by ensuring the comparable attractiveness of the offer for both health and social care roles. We would also seek to address current disparities in high cost allowance between inner and outer London boroughs.

2. **Portability** – focuses on how we can use digital systems interoperability and solutions such as e-passports, remote supervision and digital up-skilling and other interventions to support 'one workforce' development and enable effective joint teams and seamless working and deployment across health and social care employers.

3. **Planning** – focuses on how we will strengthen our capability for pro-active, joined up, system-wide operational and strategic planning with a 'one workforce' perspective across both health and social care at system, place and neighbourhood levels.

4. **Partnership** – focuses on how we will address inequities in the system and ensure access to employment opportunities for young people, older people and under-representative groups in our populations. It includes building in a recognition of generational differences in perceptions of work and employee motivation, in the design of health and social care careers and roles that would be attractive to our future workforce.

5. **Purpose** – focuses on how we will strengthen collaboration between schools and higher education institutions and health and social care providers, to develop and train a continuous supply pipeline of talent to be channelled into innovative flexible careers through apprenticeships, and redesigned roles, skills and entry requirements.

6. **Population** – focuses on how we will engage with our residents, under-represented groups, young people, older people in our diverse communities to co-design work opportunities and recruitment and retention strategies that work for them.

7. **Productivity** – focuses on how we will put in place interventions to support, develop and ensure the health and mental well-being and resilience of all our system health and social care workforce, including in primary care, the voluntary and independent care sectors, so as to enable and retain a productive, motivated and sustainable 'one workforce'.

The significant diversity of our NEL local communities places a premium to ensure that addressing inequalities, promoting diversity and inclusion, and enabling anti-racist organisations across NEL health and social care remains a central focus in taking forward each one of these high-level people and workforce strategic priorities. (See Appendix 2)

3.0 Background

3.1 How we have done it – Our approach centred on:

1. System-wide Engagement

Beginning with a voluntary sector workshop in October 2022 followed by our first system-wide workforce strategy workshop in November 2022 we have engaged widely across our NEL health and social care partnership. Between February and April 2023, we held bespoke, sector-specific workshops including with primary care providers, Care Provider Voice and the independent care sector and higher education providers.

We also engaged individually and in joint sessions with Local Authority Chief Executive officers (CEOs) and Place Leads, Directors of Adult and Children's Social Care, Directors of Nursing, Directors of Public Health, our Acute, Mental Health and Community provider collaboratives, Trust Chief People Officers (CPOs), our Anchor Organisations programme lead. We held our second system–wide workshop on 24 April 2023 to wrap up Phase 1 and produce our high-level strategic priorities. The workshop was well attended with 54 participants and wide representation from across the system. (See Appendix 3).

At each workshop and engagement session, we mapped existing good collaborative practice and what was already working well, acknowledged the starting context and needed improvements, but more importantly we challenged participants to look well into the future and to envision what good looks like and the art of the possible. The overall takeaway was that we need to do things differently across the system, in order to attract the young generation and under-represented groups in our populations into employment as we seek to develop a sustainable, skilled, motivated and inclusive 'one workforce' for health and social care across NEL.

2. Detailed NEL Borough Demographic Analysis

We conducted a detailed borough by borough demographic analysis of our NEL populations to understand the make-up of our potential and future workforce. (See details in Appendix 4 and summary in Appendix 5)

The demographic analysis highlighted the need for our system people and workforce strategies to be Inclusive, innovative, adaptable and flexible, so as to leverage the collective strengths implicit in the rich diversity of our NEL populations. Health and

social care careers will need to be innovative, flexible and redesigned to include new roles that support new ways of working so as to offer more employment opportunities for our local populations. Our recruitment strategies will need to re-focus on skills and values rather than job bands and grades and entry barriers and cumbersome application processes will need to be removed.

The analysis further reinforced that there are no 'one size fits all' solutions and our workforce retention and health and well-being strategies, will need to be innovative, targeted, locally-tailored, inclusive and culturally-specific. Key enablers at System, Place, Neighbourhood and in our Collaboratives to ensure delivery of these strategic objectives will need to be identified and agreed in collaboration with key stakeholders as part of the five-year action plan.

3. Identification of Key Themes

We identified emerging themes which contributed to the development of our seven strategic priorities. One theme, for example, highlighted significant generational differences and the changing meaning, perception and composition of work and employment motivators, between our young and older people. This will be a critical driver to the design of health and social care careers and roles with flexible terms and conditions that will attract and retain our future NEL workforce.

Another key theme was around the need to develop people and workforce strategies that will apply to and enable the full representation and inclusion of 'all' of our NEL system workforce - with a keen focus on increasing engagement with our largely fragmented primary care, social care and voluntary sector workforce, that is spread across lots of independent and different employers. This will help us to have a truly NEL- wide 'One' workforce.

An optional pre- reading pack with more background detail from Phase 1 engagement is included in Appendix 6.

3.2 Next Steps (see Phase 2 plan and timeline in Appendix 7)

1. In phase 2, we are continuing to engage with key system stakeholders. We will be engaging with our staff both in the ICB and across NEL ICS, including with Trusts, Local Authorities, Primary Care, Independent Care providers and the Voluntary sector, to include their voice and input to the strategy development, though mini-hackathons, face to face and virtual sessions, and other existing staff forums in Trusts and at Place. Our first mini-hackathon was held on 4 July at Unex Tower.
2. We will also be engaging with our residents at Place – including with young people, older people, under-represented groups, carers, faith leaders, refugees, etc to include their voice and to understand their needs and what will work for them.
3. We are working closely with our communication engagement teams and Place leads to link into career fairs and other work-based events; carers and volunteer networks and with Healthwatch for further community outreach. We will be interfacing with the 'Big Conversation' across NEL.
4. We are in the process of setting up Task and Finish groups across the system to take forward the seven high-level strategic priorities and translate these into detailed short, medium, and long-term action plans as part of the five-year strategy delivery plan. The Terms of Reference will include to identify immediate quick wins and agree one or two priority actions that will be achievable in year 1. We will also encourage planning with a long-term view by horizon scanning and forecasting over the next 20 years. Each Task and Finish group will develop key performance indicators and outcome measures to support proposed plans.

5. We have begun the process of engaging a System Workforce Planner to support the development of the five-year system workforce plan across health and social care.
6. We will engage with system leaders to agree a governance framework with clear accountabilities to support the delivery of the workforce strategy at:
    - System
    - Place
    - Neighbourhood

   This will ensure that the right actions are delivered at the right place with the right metrics in place to track progress.
7. The NEL People Board will oversee the actual delivery of the strategy across the system and will have executive oversight from the Executive Committee and our partners. The NEL People Board will also link into the London People Board.
8. We aim to finish the detailed action planning phase by the autumn.
9. We plan to present the final People and Workforce Strategy and Five-Year Plan to the Board for approval in November.

4.0 Risks and mitigations

4.1 There is a risk that this wider engagement could be met with a 'what's in it for them' question from some partner organisations with increased expectations for system support from the ICB, in areas such as funding, influence, estates, digitalisation etc.

5.0 Recommendations

5.1 The Board is asked to approve the high-level strategic priorities and to endorse the next steps.

6.0 Attachments

6.1 The following attachments accompany the report.

- Appendix 1 (NHS Workforce Plan Summary)
- Appendix 2 (Our High-Level Strategic Plan Priorities)
- Appendix 3 (System- wide Engagement)
- Appendix 4 (North East London Population Workforce Numbers)
- Appendix 5 (Population Analysis Summary)
- Appendix 6 (Pre- Reading Pack - Optional)
- Appendix 7 (Phase 2 Timeline)

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7.0 End

7.1 Susan Nwanze, Interim Director of OD and Education

NHS Long Term Workforce Plan

Brief guide from NHS England – June 2023

The NHS is nothing without our people, the NHS Long Term Workforce plan is a once in a generation opportunity to put the NHS on a sustainable footing to deliver high quality patient care now and in the long term. This briefing sets out what the plan means for you and your teams.

The Plan sets out an expansion in training, changes to ways of working, and improvements to culture that will increase the NHS permanent workforce over 15 years, this could mean at least an extra

- 60,000 doctors,
- 170,000 nurses
- 71,000 allied health professional (AHPs)

The plan also sets out that there will be an expansion in the number of new roles such as physician associates and nursing associates. We will also increase the number and proportion of apprenticeships, creating opportunities for people to join the NHS from a range of different backgrounds and with a wealth of different experiences.

This plan sets out supply and demand scenarios and a range of projections for key workforce groups and professions over the short, medium and long term which will be repeated regularly as part of the NHS planning round.

The case for change

There were over 112,000 vacancies across the NHS in March 2023: an 8.0% vacancy rate. Levels of staffing in the NHS are proportionally lower than other comparable health systems internationally. An ageing population, growing demand, and the opportunity presented by technology, mean that work in healthcare will be dramatically different in future.

We need to take steps now to meet these challenges. Without immediate action we expect the workforce shortfall will grow to **between 260,000–360,000 FTEs by 2036/37,** even with ambitious productivity assumptions, this shortfall would include:

- 15,000 GPs
- 37,000 community nurses
- 17,000 mental health and learning disability nurses

While the above looks stark and we cannot deny there are challenges ahead, there are also significant opportunities. This Plan sets out a series of actions, reforms and proposals to demonstrate how the expected shortfall could be closed.

Headline Proposals:

	**Train: Growing the workforce** We will train over 450,000 healthcare professionals over the next five years. This means that by 2028: • Medical training places will grow by 33% to 10k a year • Nurse training places will grow by 34% to 40k a year • AHP training places will grow by 13% to 17k a year • Training places for new roles such as nursing associates, advanced care practitioners, anaesthesia associates, peer support workers and others will grow by more than 30% to nearly 16k a year • Pharmacy training places will grow by 29% to 4,300 a year • Grown the number of support to clinical workers by more than 110,000 • The number of GP training places will grow by 25% to 5k a year NHS recruitment processes will be reformed to support this growth and ensure NHS organisations support their local job market.
	**Retain: existing talent** Retention improvements can contribute to retaining up to 130,000 more staff in the NHS. To make this a reality, the NHS will need to continue to improve culture, inclusion and ways of working and make the NHS People Promise a reality for everyone. This includes better opportunities for career development, improved flexible working options, alongside government reforms to the pension scheme
	**Reform: Working and training differently** • We will take full advantage of digital and technological innovations, such as Artificial Intelligence (AI), speech recognition, robotic process automation (RPA) and remote monitoring, to provide a more efficient service for staff and patients. • To ensure patients benefit from a broader range of skilled professionals**,** we will increase the proportion of new roles from 1% of the workforce in 2022 to 5% by 2036/37. • We will expand clinical apprenticeships from 7% of training places today to 22% by 2030. • We will work with universities to improve student experience, reducing leaver rates from courses, and using new technology to prepare people for work in a modern NHS.

What will be different for our NHS Staff?

Change needs to be clear, tangible, and meaningful for our staff, the plan commits the NHS to:

	Support our staff to enjoy more flexible careers – working in ways that suit them and having flexibility to progress in to new roles.
	Overhaul our NHS recruitment processes, including by ensuring it takes no longer than six weeks from the placement of a job advert to the completion of a candidate's pre-employment checks
	Put staff sharing agreements in place to make it as easy as possible to work across organisational boundaries
	Deliver on the commitments in the NHS People Promise with a clear employee value proposition, ensuring we can attract and retain talent, and deliver the actions in the NHS equality, diversity and inclusion plan
	Reduce our reliance on agency staff by making staff banks the most attractive route to help fill short-term gaps

If implemented in full, this would mean:

- Leaver rates improve around 15% over the course of the Plan, and retention will be at rates better than the average pre-pandemic.
- A higher proportion of new joiners to the NHS workforce would come from training and education routes rather than from overseas, and within those, a greater proportion would train via apprenticeship routes.
- By 2028 there will be 34% more nurses trained per year in England and medical school places would increase by a third.
- By 2031, the number of apprentices will represent 22% of all people in clinical training across the NHS.
- There will be a significant increase in the number of trainers and educators working across the NHS, to support growth in training places.
- Materially reducing staff shortfalls by 2028 and further reduce to minimal levels thereafter.

Top lines

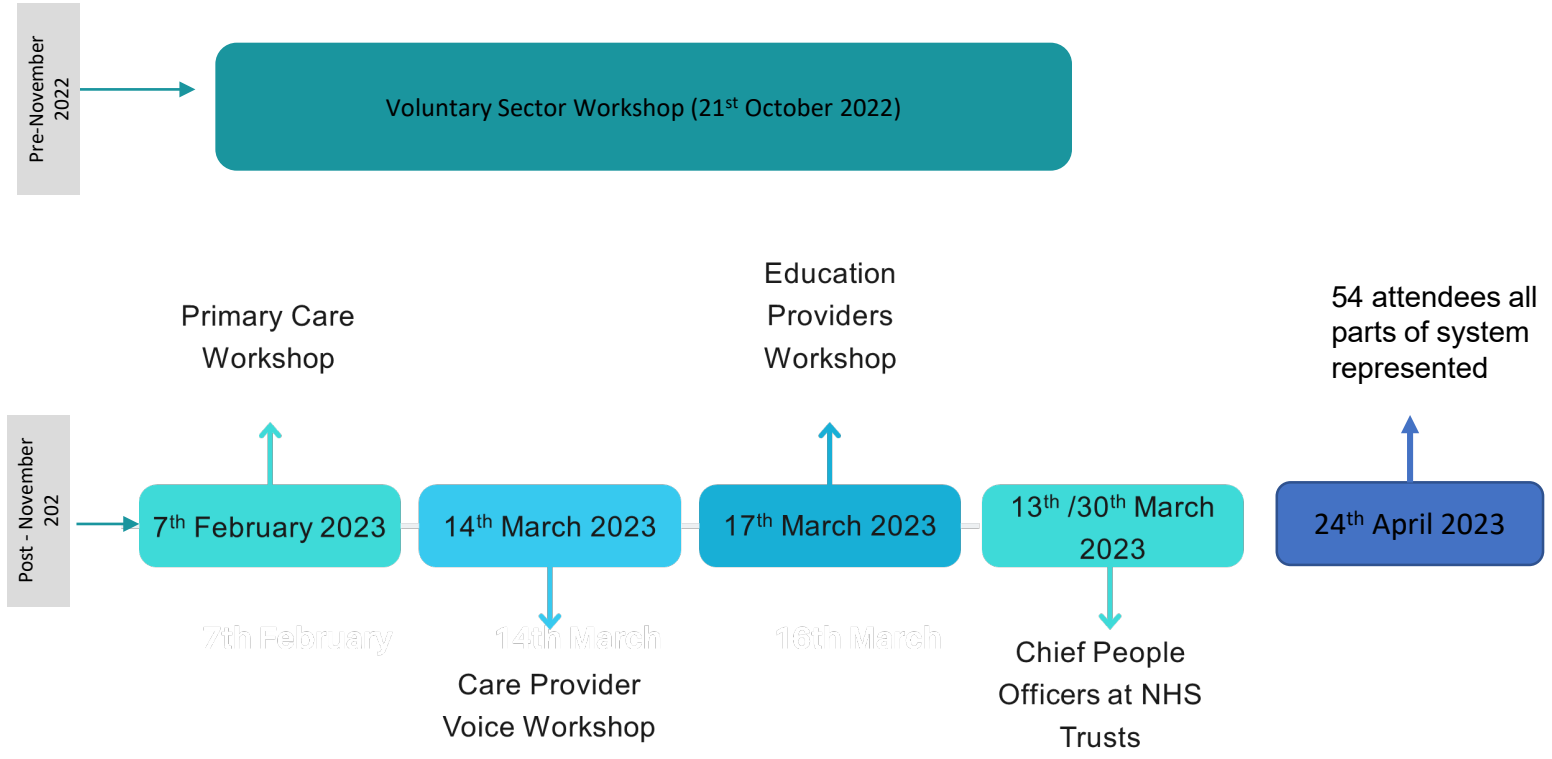
- We know the NHS is nothing without its workforce and this plan will deliver the biggest increase in training numbers in our 75-year history.
- This is the first time that the government has asked the NHS to come up with a comprehensive workforce plan and it is a once in a generation opportunity to put staffing on a sustainable footing.
- We are going to train record numbers of doctors, nurses, dentists, physiotherapists and other key healthcare staff to address the gaps we have in the current workforce and meet the challenge of a growing and ageing population.
- Since the founding of the NHS 75 years ago, we have relied on the amazing skill and dedication of staff who came here from around the world, starting with Windrush and there will always be a place for them in the NHS.
- But demand for the skills and dedication of healthcare workers is only going to grow in every country around the world so we need to end the overreliance on recruitment from overseas.
- We also want to draw on the widest possible pool of talent. Which is why we are increasing alternative routes into NHS careers with more people able to get a nursing or medical degree through an apprenticeship.
- By addressing workforce gaps, we can tackle the covid backlogs that have inevitably built up over the pandemic, not just helping patients but also boosting the economy by helping get people back to work.
- This plan isn't just about increasing numbers, it is about working differently to maximise the benefit of new tech, therapies and treatment.
- It is also about retaining the staff we have – by boosting flexibility in roles and supporting the wellbeing of our staff, we can ensure fewer staff leave the NHS over the next 15 years.
- NHS England intends to publish further iterations of the NHS Long Term Workforce Plan at least every two years, to reflect the progress that has been made in delivering the actions set out here, and to take account of changes to the way services and care may be delivered in future.

Our High Level Strategic Plan Priorities Appendix 2

- **Parity** – focuses on how we can achieve better equity in pay and benefits between health and social care employment terms and conditions.
- **Portability** – focuses on how we can use digital systems interoperability and solutions such as e-passports, remote supervision and digital up-skilling and other interventions to support 'one workforce' development and enable effective joint teams and seamless working and deployment across health and social care employers.
- **Planning** – focuses on how we will strengthen our capability for pro-active, joined up, system-wide operational and strategic planning with a 'one workforce' perspective across both health and social care at system, place and neighbourhood levels.
- **Partnership –** focuses on how we will address inequities in the system and ensure access to employment opportunities for young people, older people and under-representative groups in our populations.
- **Purpose** – focuses on how we will strengthen collaboration between schools and higher education institutions and health and social care providers, to develop and train a continuous supply pipeline of talent to be channelled into innovative flexible careers through apprenticeships, and redesigned roles, skills and entry requirements.
- **Population** – focuses on how we will engage with our residents, under-represented groups, young people, older people in our diverse communities to co-design work opportunities and recruitment and retention strategies that work for them.
- **Productivity** – focuses on how we will put in place interventions to support, develop and ensure the health and mental well-being and resilience of all our system health and social care workforce, including in primary care, the voluntary and independent care sectors, so as to enable and retain a productive, motivated and sustainable 'one workforce'.

Our engagement with System Partners

Appendix 3



We have engaged with about 40 people individually and jointly including:

- Local Authorities/Place Leaders – On-going engagement.
  - Initial engagement meetings held with Havering, Newham and Redbridge Chief Executive Officers.
- Collaboratives – Acute, Mental Health, Community – On-going engagement
- Anchor Organisations Programme Lead – On-going engagement on programme progress and updates
- Voluntary Sector Stakeholders - On-going engagement

NHS
North East London

Population, workforce and unemployment Summary

All Boroughs in North East London

Intelligence Solutions for London

Barking and Dagenham Population – By Age Band

218,354

112,136

106,398

2021 ONS Mid year estimate population of Barking and Dagenham

51.3% of the population is female

48.7% of the population is male

142,565

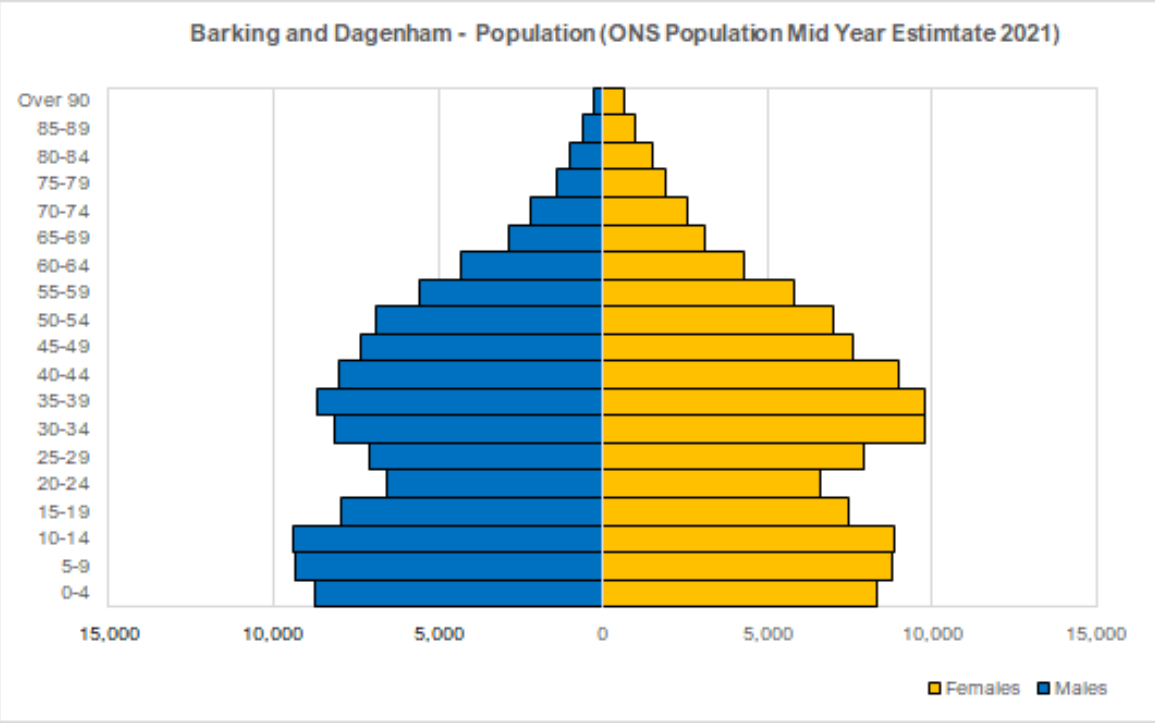
73,688

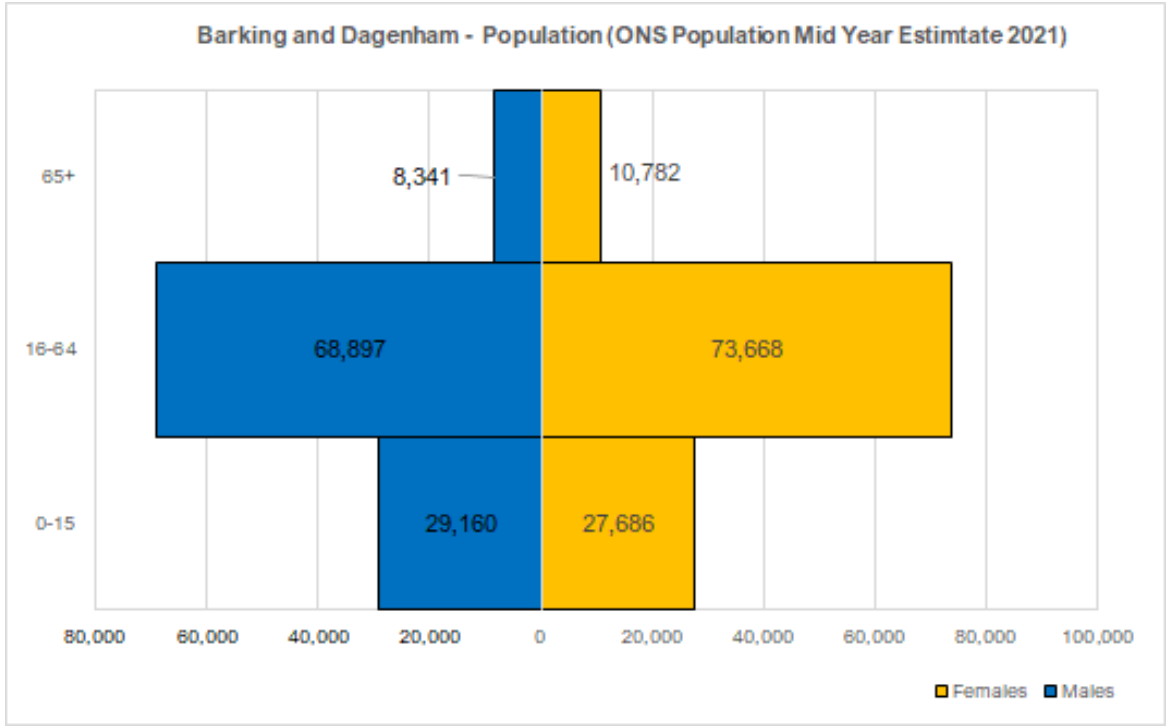
68,897

65.2% of the population Is classified as working age 16-64

65.7% of the female population Is classified as working age 16-64

64.8% of the male population Is classified as working age 16-64





Data Source: [Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)]

Barking and Dagenham – Population Diversity

217,180 — 2021 ONS census population of Barking and Dagenham

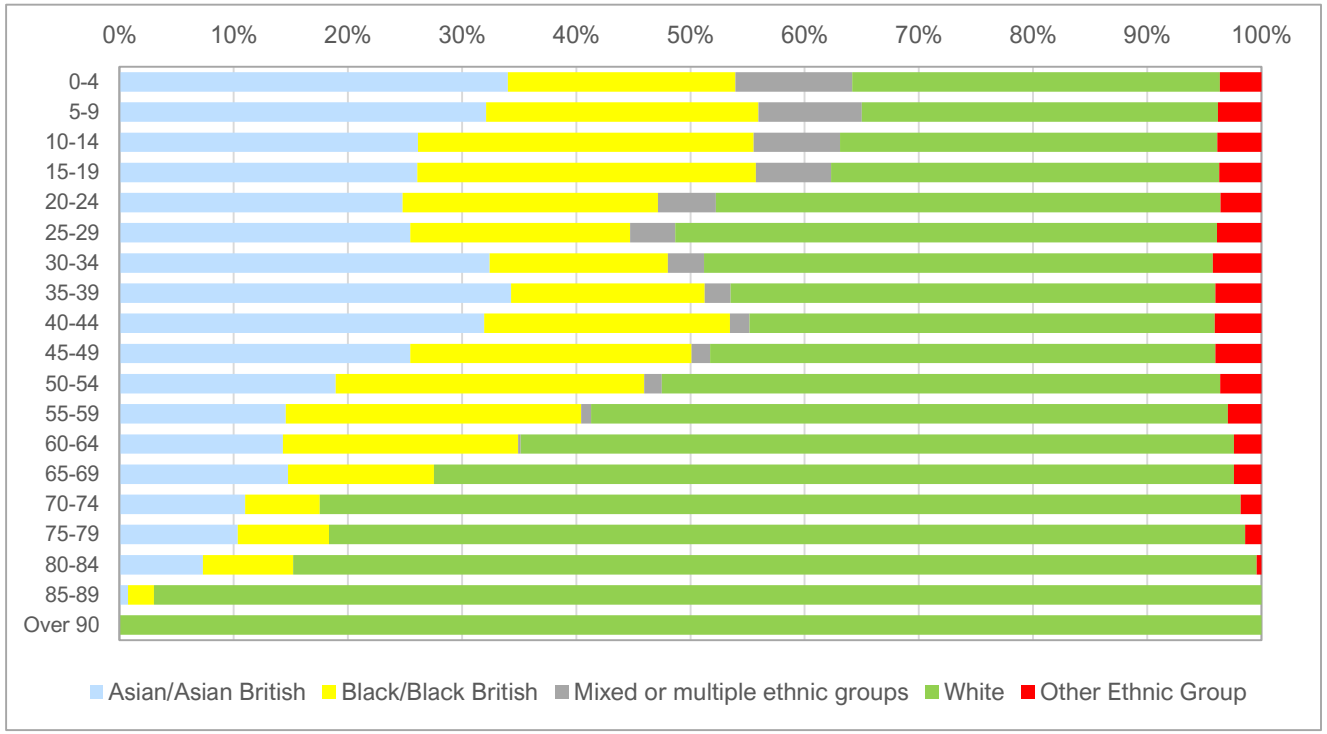
56,280 — **25.9%** of the population is Asian/Asian British

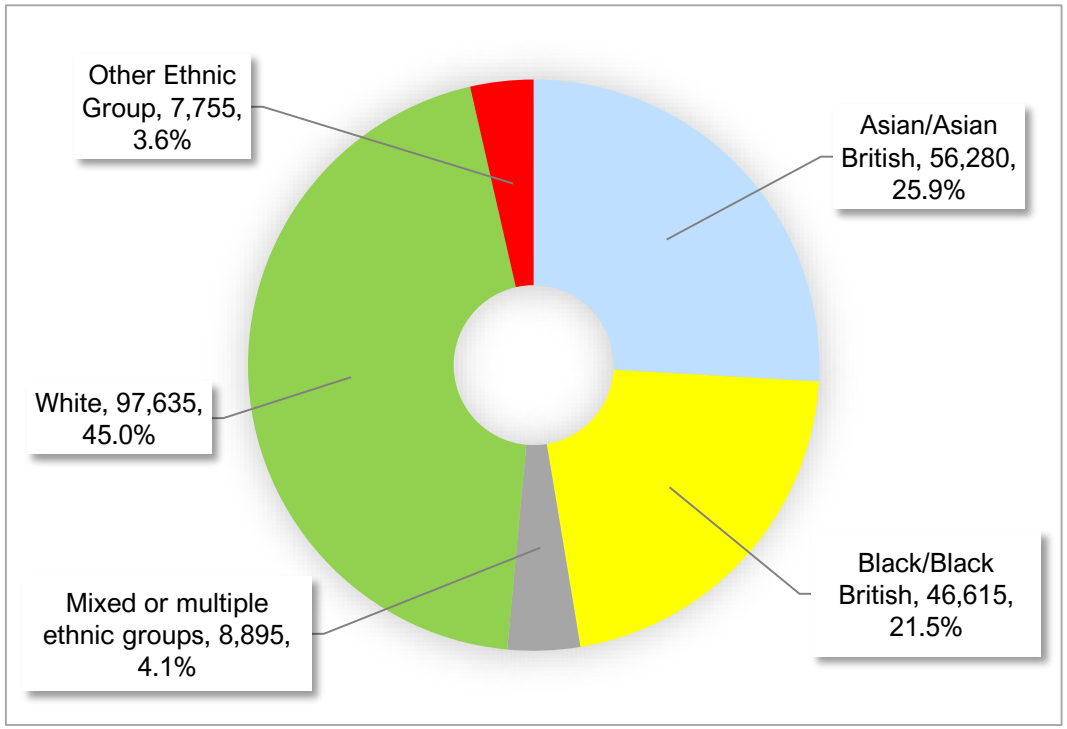
46,615 — **21.5%** of the population is Black/Black British

8,895 — **4.1%** of the population is Mixed or Multiple ethnic groups

97,635 — **45.0%** of the population is White/White British

7,755 — **3.6%** of the population is Other





Data Source: [Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)]

Barking and Dagenham – Population Diversity 16 to 64

141,995 — 16 to 64 ONS census population of Barking and Dagenham

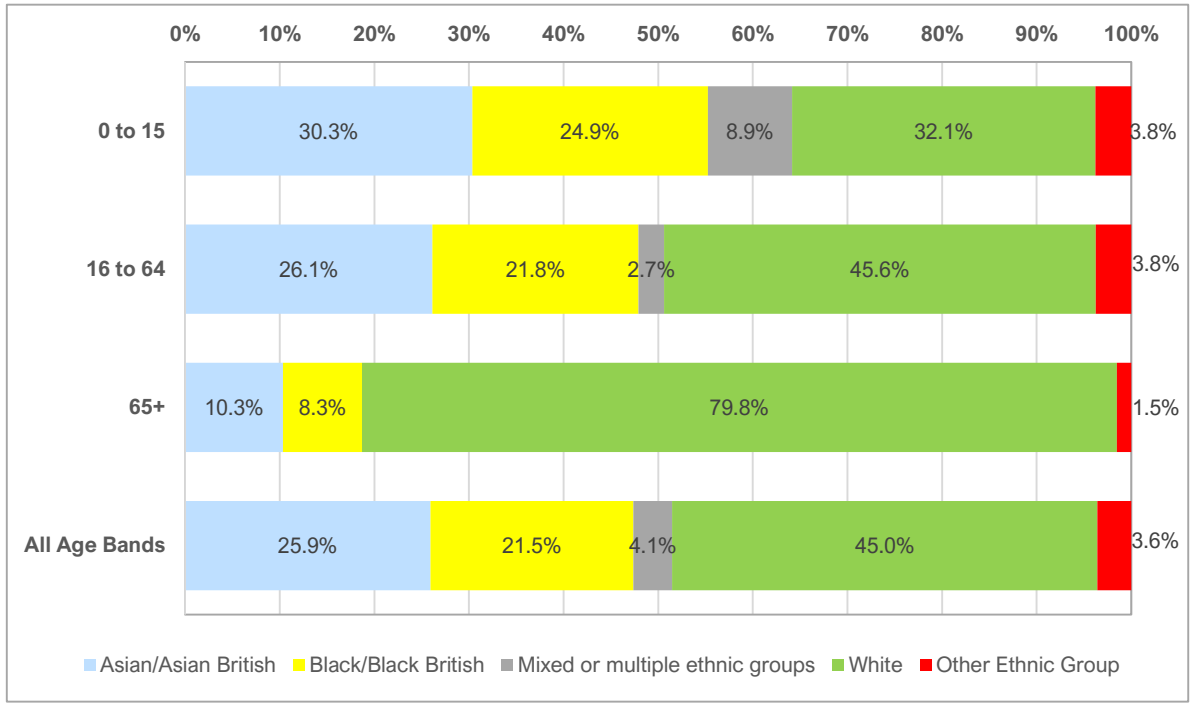
37,115 — **26.1%** of the 16-64 population is Asian/Asian British

30,925 — **21.8%** of the 16-64 population is Black/Black British

3,825 — **2.7%** of the 16-64 population is Mixed or Multiple ethnic groups

64,805 — **45.6%** of the 16-64 population is White/White British

5,325 — **3.8%** of the 16-64 population is Other



Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	17,275	14,165	5,070	18,260	2,150	56,920
16 to 64	37,115	30,925	3,825	64,805	5,325	141,995
65+	1,890	1,525	0	14,570	280	18,265
All Age Bands	**56,280**	**46,615**	**8,895**	**97,635**	**7,755**	**217,180**

Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	30.3%	24.9%	8.9%	32.1%	3.8%	100%
16 to 64	26.1%	21.8%	2.7%	45.6%	3.8%	100%
65+	10.3%	8.3%	0.0%	79.8%	1.5%	100%
All Age Bands	**25.9%**	**21.5%**	**4.1%**	**45.0%**	**3.6%**	**100%**

In Barking and Dagenham the population is more diverse in the 0 to 15 and 16 to 64 age bands with higher proportions of all ethnic groups apart from White. As the 0 to 15 age bands move into working age the diversity of the working age population is set to increase.

Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Barking and Dagenham - Workforce

Primary Care Workforce – Headcount as at Jan-2023

33	**No of GP Practices in Barking and Dagenham**			
294	GPs	124	Nurses	
94	Other Healthcare Professional	642	Admin- Clinical Support	

Residential Care Home Workforce – Headcount as at Feb-2023

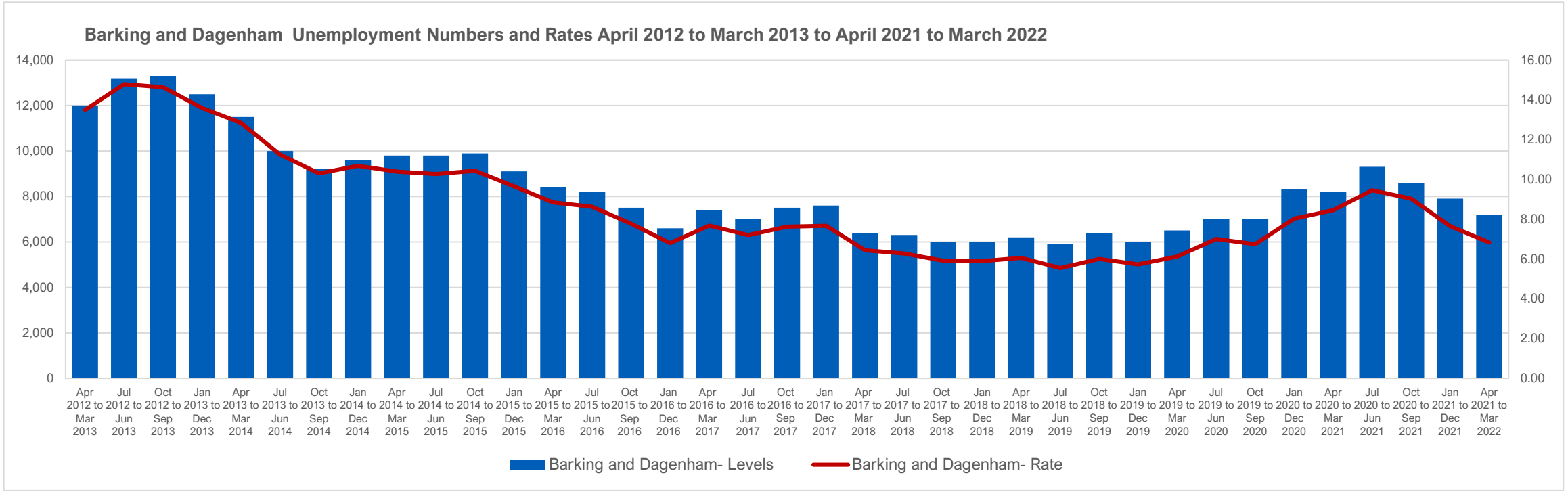
22	**No of Residential Care Homes in Barking and Dagenham**
95	Nurses, 87.2% substantive, 12.8% Agency
735	Care Workers, 91.3% substantive, 8.7% Agency
216	Non Care Workers, 92.3% substantive, 7.7% Agency

Data Source : NHS Digital and NECS Capacity Tracker

Barking and Dagenham Population – Unemployment Figures

7,200 Unemployed in Barking and Dagenham as at April 2021 to March 2022

Unemployment Rate **6.8** as at April 2021 to March 2022

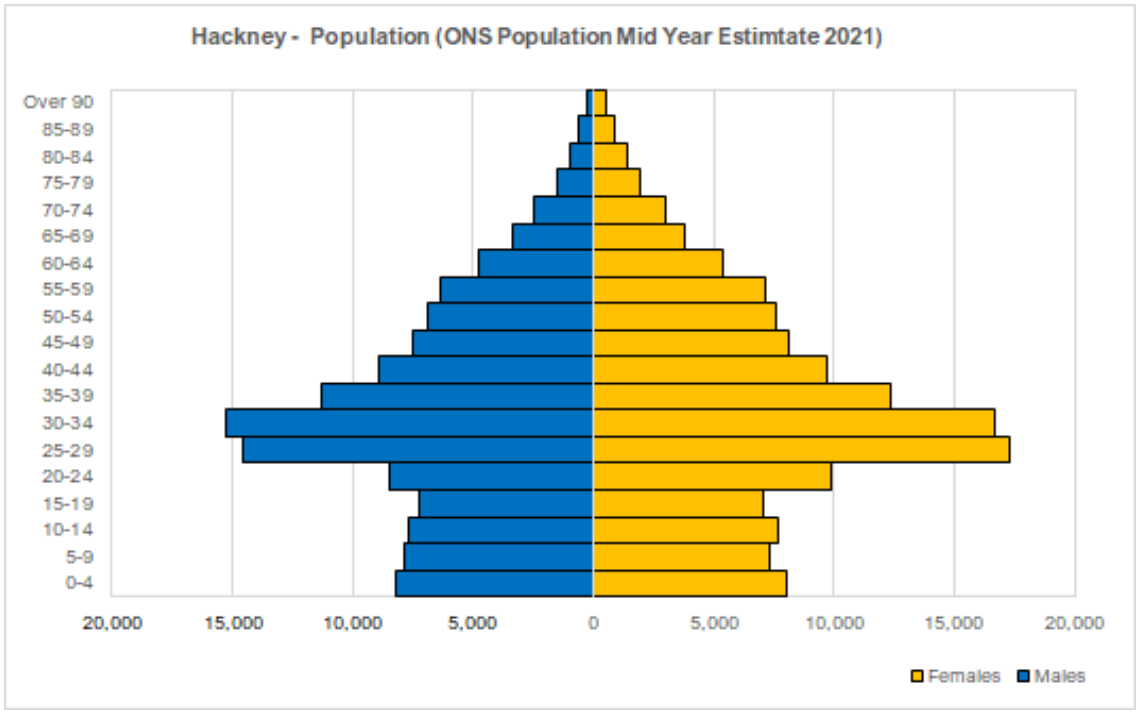


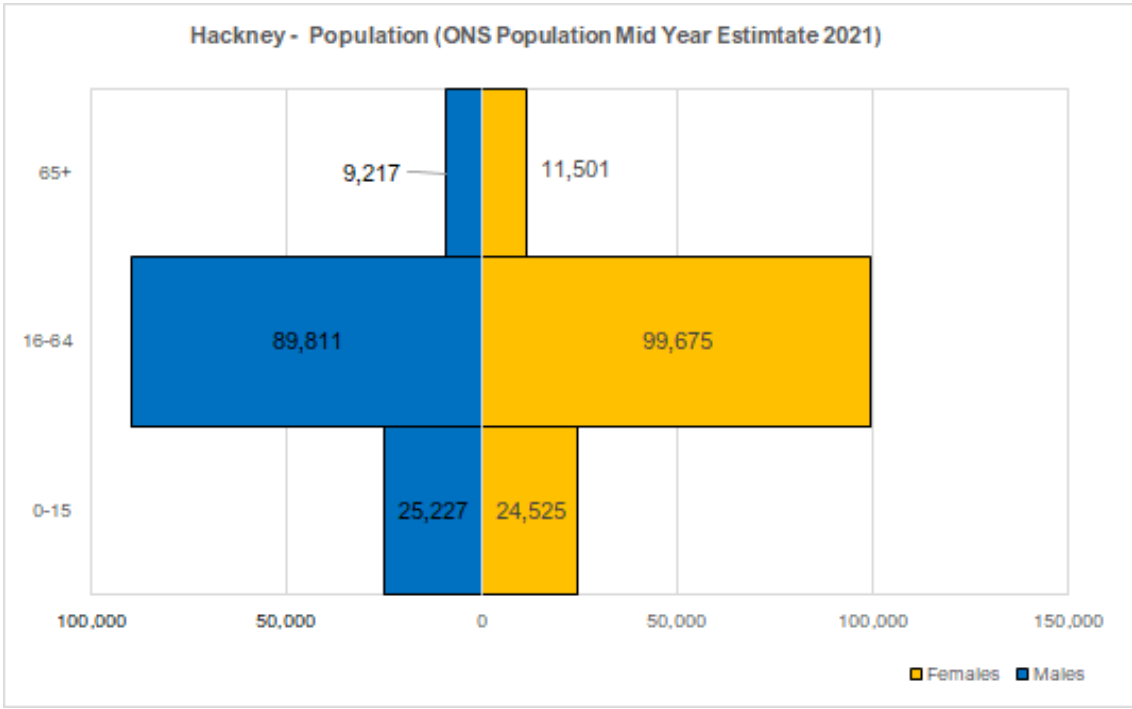
Historically unemployment numbers and rates have been reducing in Barking and Dagenham since April 2012

Data Source: M01 Regional labour market: Modelled unemployment for local and unitary authorities - Office for National Statistics (ons.gov.uk)

Hackney Population – By Age Band

259,956	2021 ONS Mid year estimate population of Hackney	189,486	72.9% of the population Is classified as working age 16-64
135,701	51.3% of the population is female	99,675	73.5% of the female population Is classified as working age 16-64
124,255	48.7% of the population is male	89,811	72.3% of the male population Is classified as working age 16-64





Data Source: [Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)]

Hackney – Population Diversity

257,740 — 2021 ONS census population of Hackney

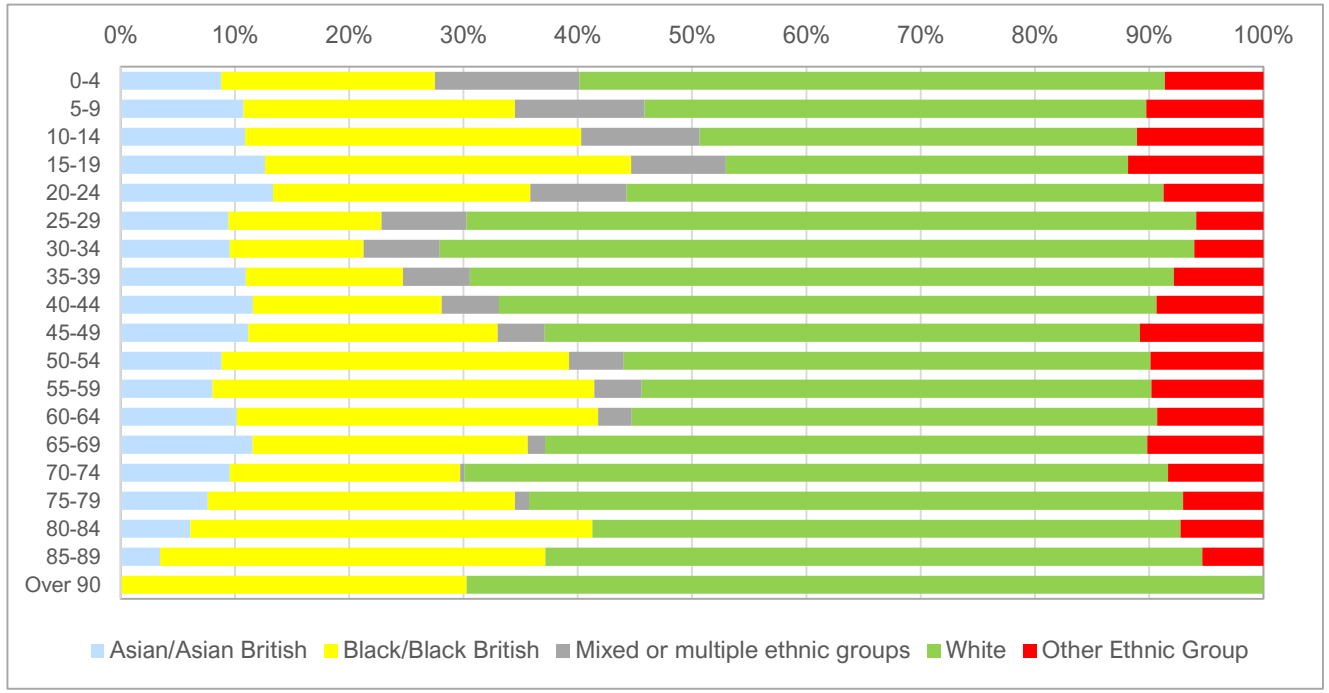
26,565 — **10.3%** of the population is Asian/Asian British

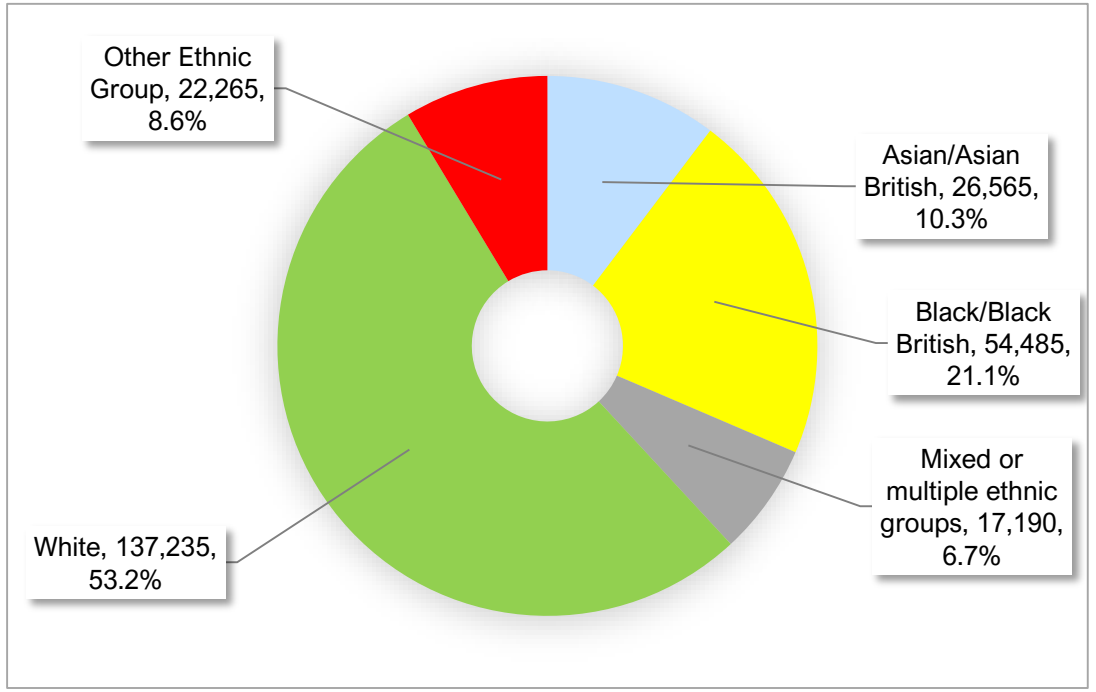
54,485 — **21.1%** of the population is Black/Black British

17,190 — **6.7%** of the population is Mixed or Multiple ethnic groups

137,235 — **53.2%** of the population is White/White British

22,265 — **8.6%** of the population is Other





Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Hackney – Population Diversity 16 to 64

188,615

16 to 64 ONS census population of Hackney

19,770

10.5% of the 16-64 population is Asian/Asian British

37,440

19.8% of the 16-64 population is Black/Black British

11,420

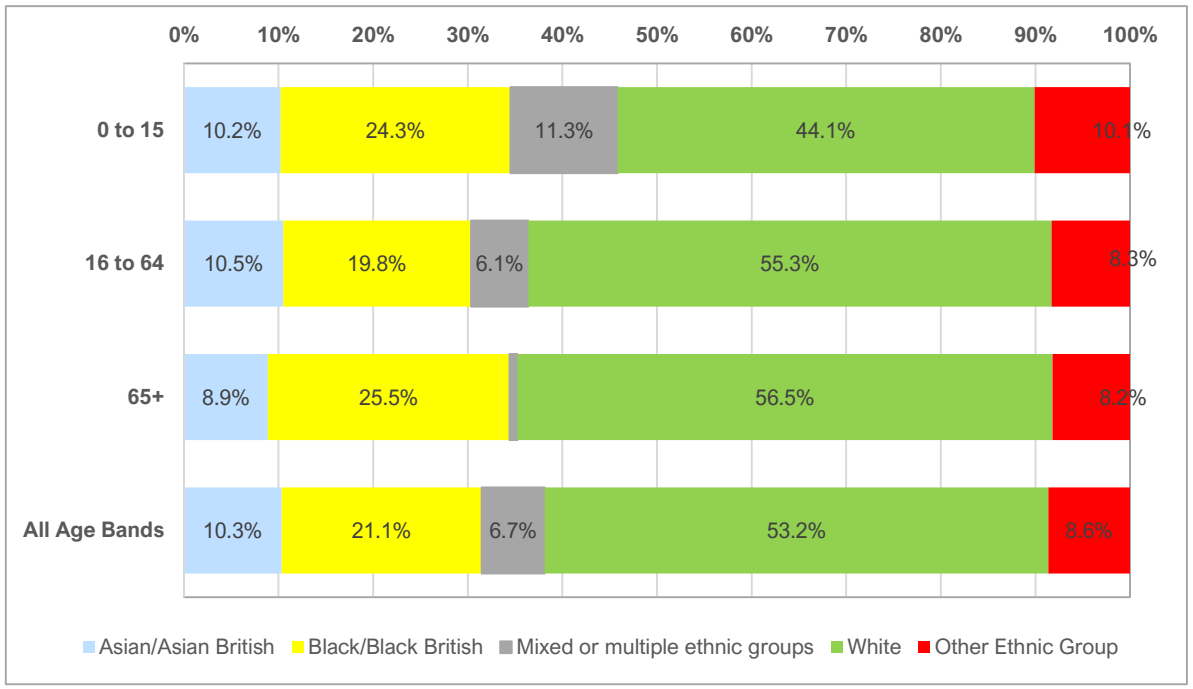
6.1% of the 16-64 population is Mixed or Multiple ethnic groups

104,355

55.3% of the 16-64 population is White/White British

15,650

8.3% of the 16-64 population is Other



Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	5,055	12,040	5,605	21,820	5,005	49,525
16 to 64	19,770	37,440	11,420	104,335	15,650	188,615
65+	1,740	5,005	165	11,080	1,610	19,600
All Age Bands	**26,565**	**54,485**	**17,190**	**137,235**	**22,265**	**257,740**

Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	10.2%	24.3%	11.3%	44.1%	10.1%	100%
16 to 64	10.5%	19.8%	6.1%	55.3%	8.3%	100%
65+	8.9%	25.5%	0.8%	56.5%	8.2%	100%
All Age Bands	**10.3%**	**21.1%**	**6.7%**	**53.2%**	**8.6%**	**100%**

In Hackney the population is more diverse in the 0 to 15 age bands with higher proportions of all ethnic groups apart from White and Asian. As the 0 to 15 age bands move into working age the diversity of the working age population is set to increase.

Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

City & Hackney - Workforce

Primary Care Workforce – Headcount as at Jan-2023

39	**No of GP Practices in City & Hackney**			
603	GPs	146	Nurses	
212	Other Healthcare Professional	864	Admin- Clinical Support	

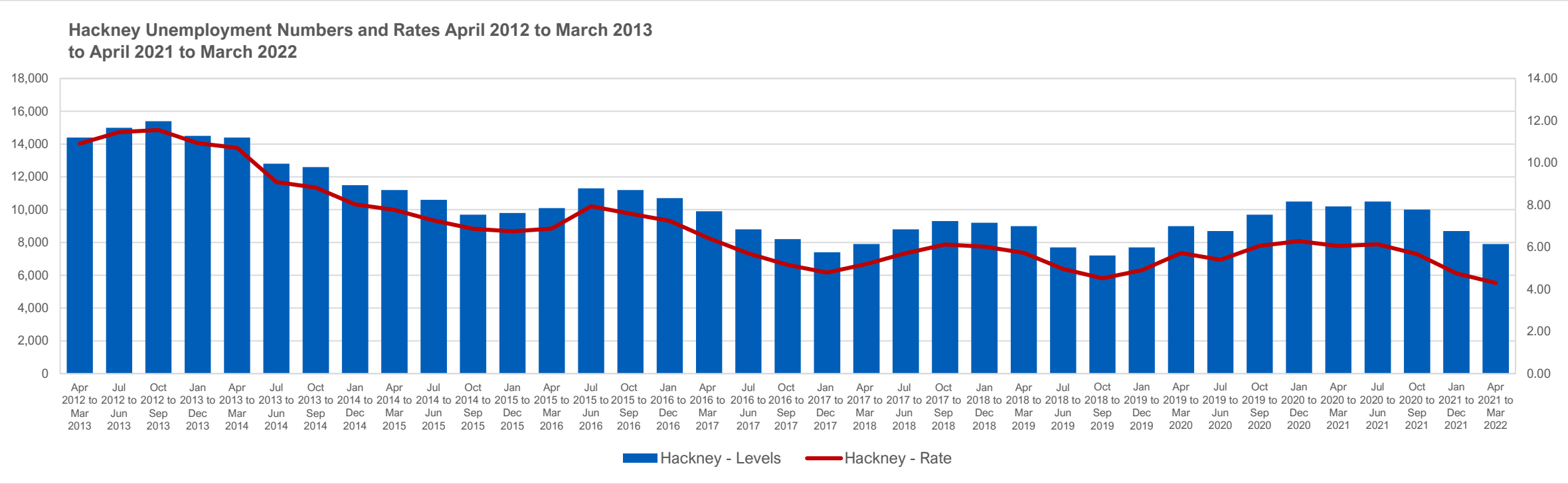
Residential Care Home Workforce – Headcount as at Feb-2023

14	**No of Residential Care Homes in City & Hackney**
56	Nurses, 92.9% substantive, 7.1% Agency
291	Care Workers, 95.9% substantive, 4.1% Agency
101	Non Care Workers, 91.1% substantive, 8.9% Agency

Hackney Population – Unemployment Figures

7,900 Unemployed in Hackney as at April 2021 to March 2022

Unemployment Rate **4.3** as at April 2021 to March 2022

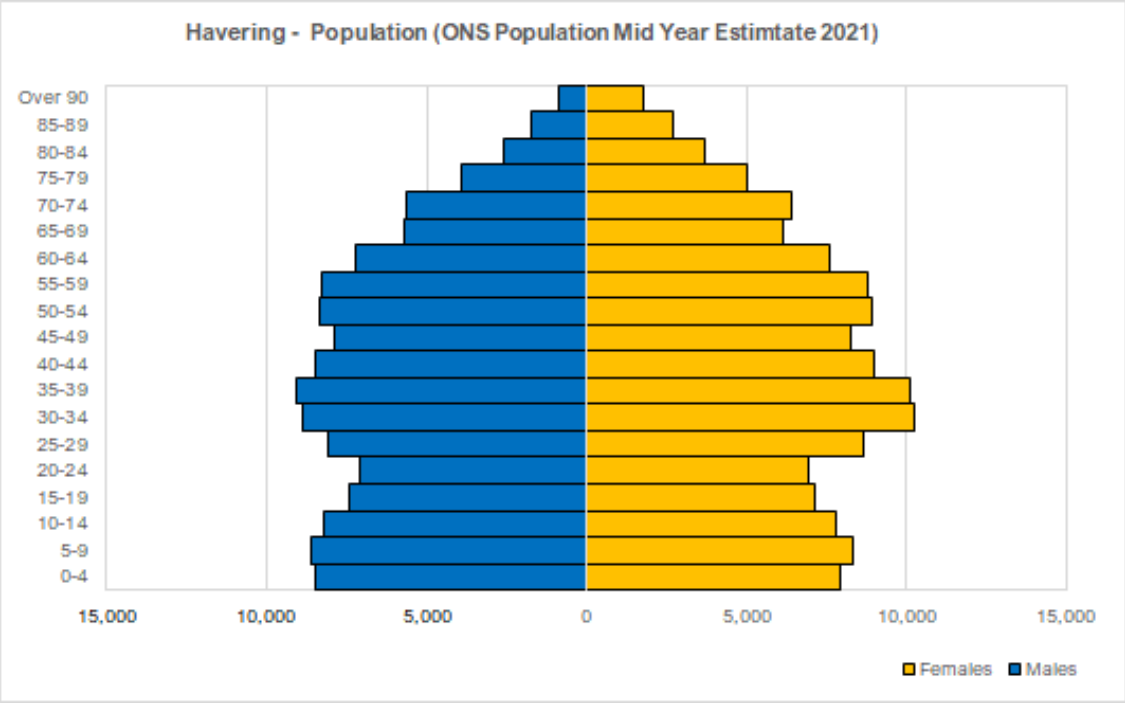


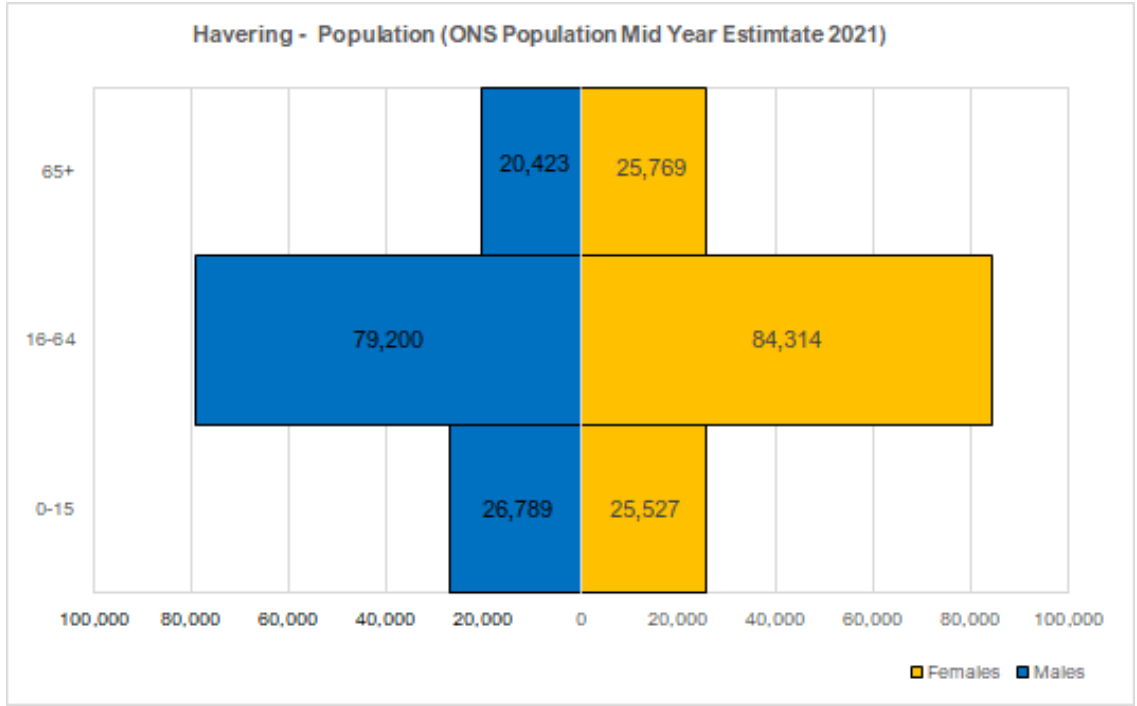
Historically unemployment numbers and rates have been reducing in Hackney since April 2012

Data Source: M01 Regional labour market: Modelled unemployment for local and unitary authorities - Office for National Statistics (ons.gov.uk)

Havering Population – By Age Band

262,022	2021 ONS Mid year estimate population of Havering	163,514	62.4% of the population Is classified as working age 16-64
135,610	51.8% of the population is female	84,314	62.2% of the female population Is classified as working age 16-64
126,412	48.2% of the population is male	79,200	62.7% of the male population Is classified as working age 16-64





Data Source: [Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)]

Havering – Population Diversity

260,145

2021 ONS census population of Havering

27,770

10.7% of the population is Asian/Asian British

21,395

8.2% of the population is Black/Black British

9,275

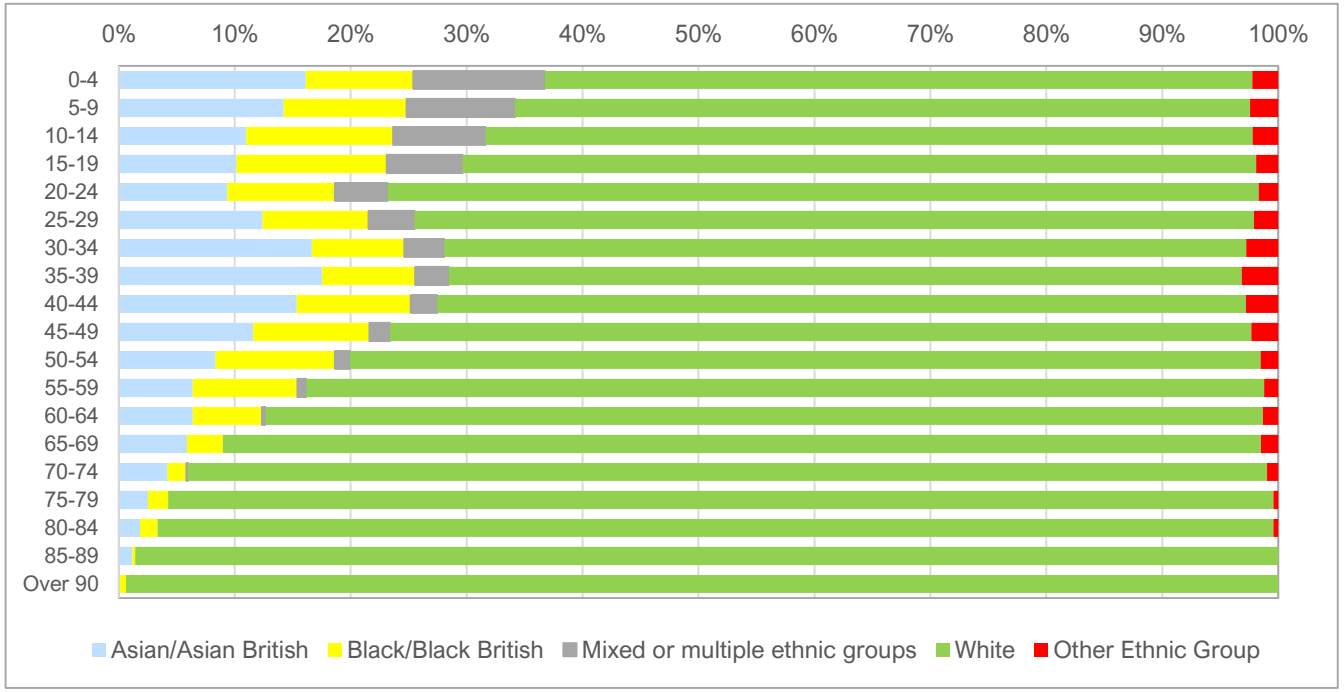
3.6% of the population is Mixed or Multiple ethnic groups

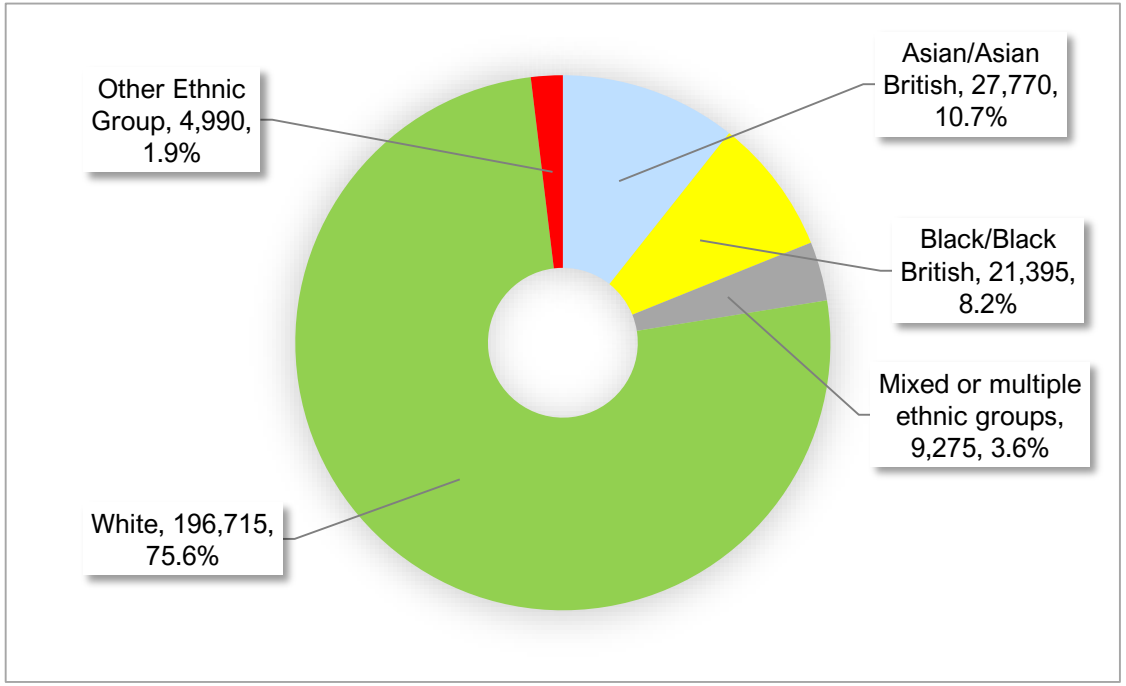
196,715

75.6% of the population is White/White British

4,990

1.9% of the population is Other

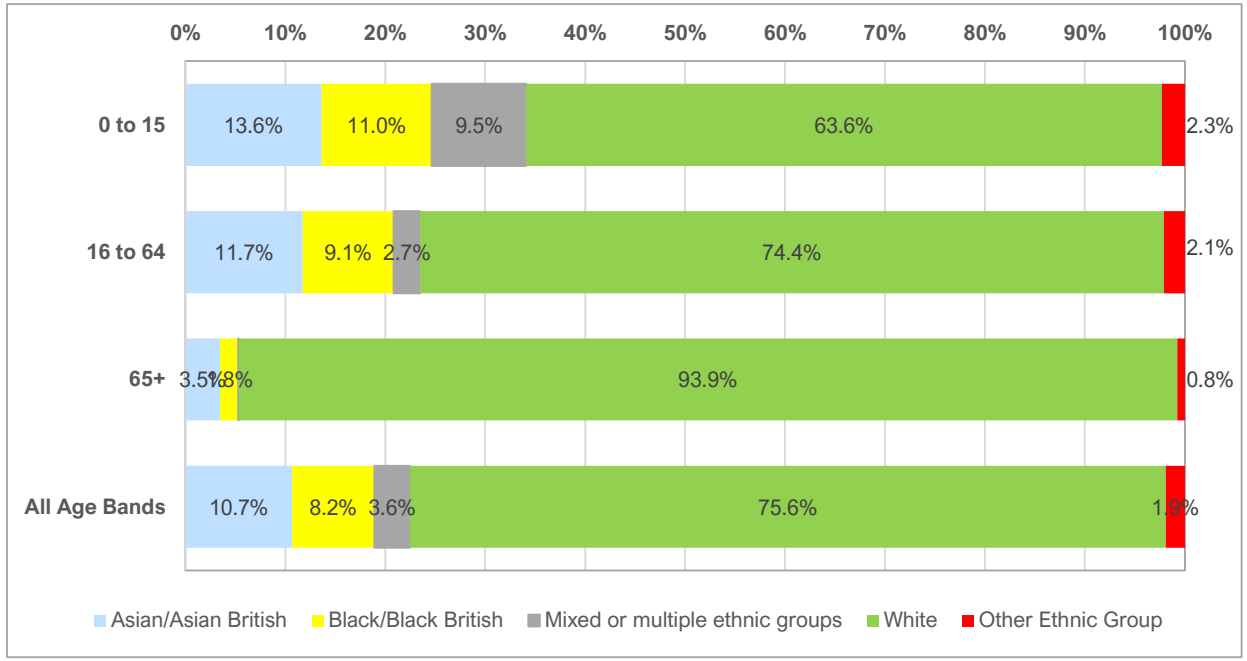




Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Havering – Population Diversity 16 to 64

162,840	16 to 64 ONS census population of Havering
19,095	**11.7%** of the 16-64 population is Asian/Asian British
14,825	**9.1%** of the 16-64 population is Black/Black British
4,335	**2.7%** of the 16-64 population is Mixed or Multiple ethnic groups
121,140	**74.4%** of the 16-64 population is White/White British
3,445	**2.1%** of the 16-64 population is Other



Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	7,100	5,745	4,925	33,145	1,195	52,110
16 to 64	19,095	14,825	4,335	121,140	3,445	162,840
65+	1,575	825	15	42,430	350	45,195
All Age Bands	**27,770**	**21,395**	**9,275**	**196,715**	**4,990**	**260,145**

Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	13.6%	11.0%	9.5%	63.6%	2.3%	100%
16 to 64	11.7%	9.1%	2.7%	74.4%	2.1%	100%
65+	3.5%	1.8%	0.0%	93.9%	0.8%	100%
All Age Bands	**10.7%**	**8.2%**	**3.6%**	**75.6%**	**1.9%**	**100%**

In Havering the population is more diverse in the 0 to 15 and 16 to 64 age bands with higher proportions of all ethnic groups apart from White. As the 0 to 15 age bands move into working age the diversity of the working age population is set to increase.

Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Havering - Workforce

Primary Care Workforce – Headcount as at Jan-2023

40	**No of GP Practices in Havering**		
454	GPs	174	Nurses
88	Other Healthcare Professional	1,188	Admin- Clinical Support

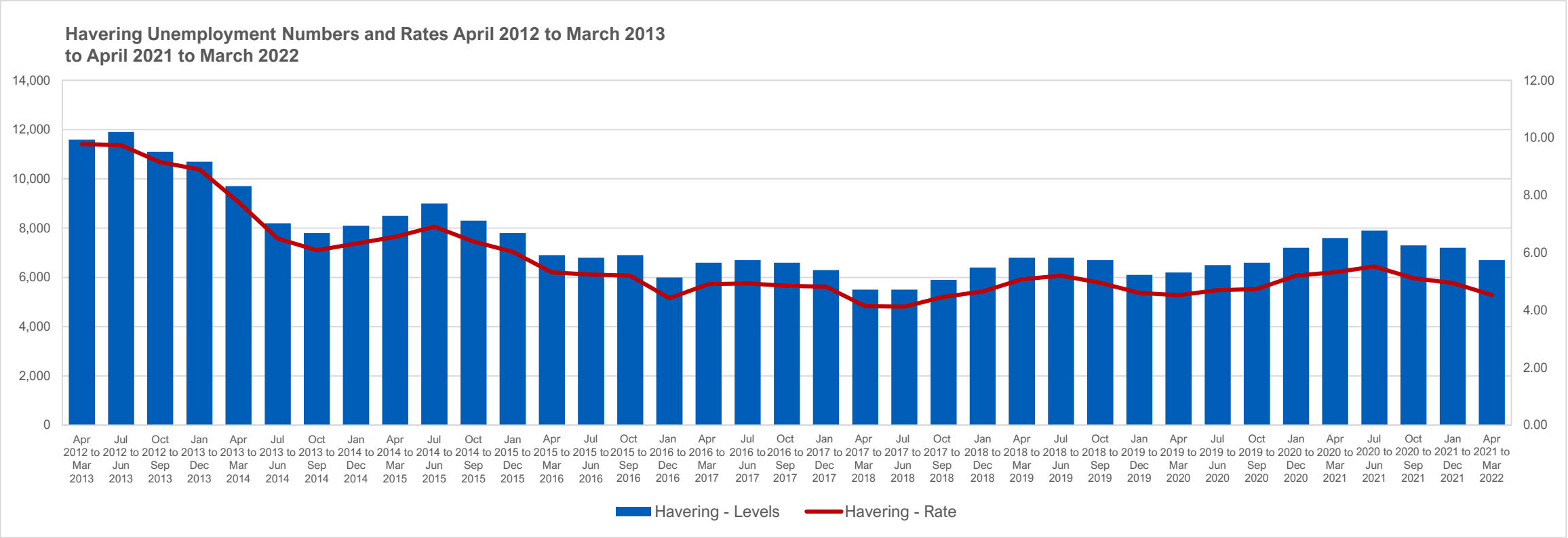
Residential Care Home Workforce – Headcount as at Feb-2023

56	**No of Residential Care Homes in Havering**
193	Nurses, 86.5% substantive, 13.5% Agency
1,620	Care Workers, 89.8% substantive, 10.2% Agency
467	Non Care Workers, 94.2% substantive, 5.8% Agency

Havering Population – Unemployment Figures

6,700 Unemployed in Havering as at April 2021 to March 2022

Unemployment Rate **4.3** as at April 2021 to March 2022

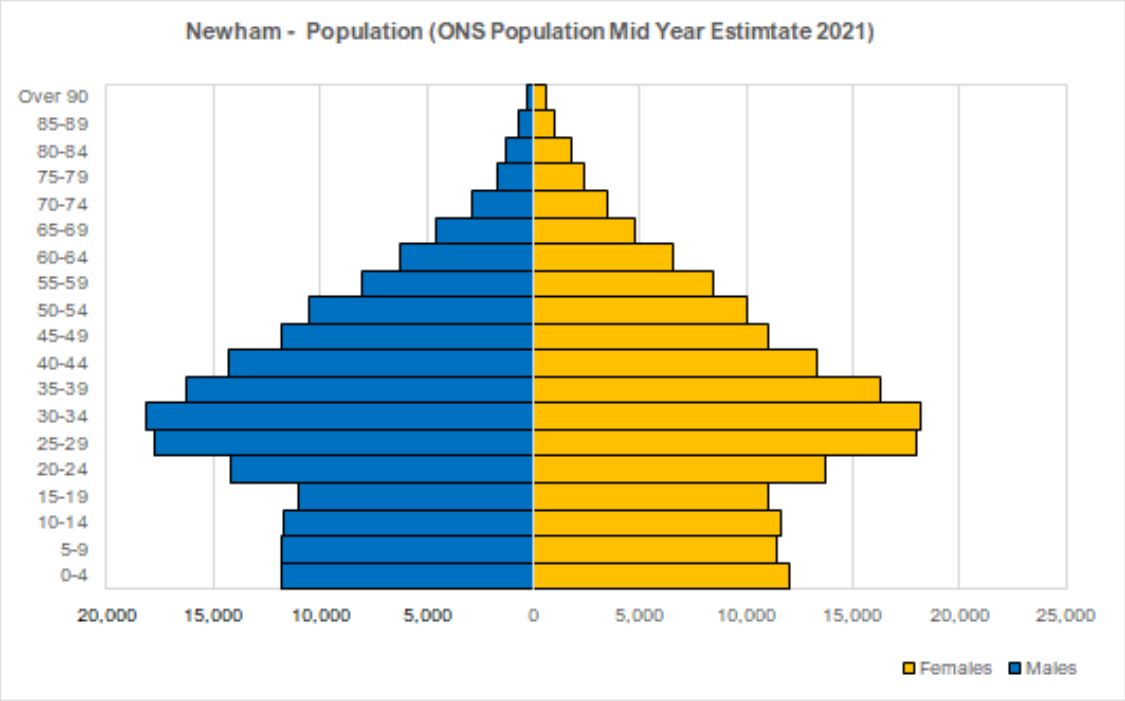


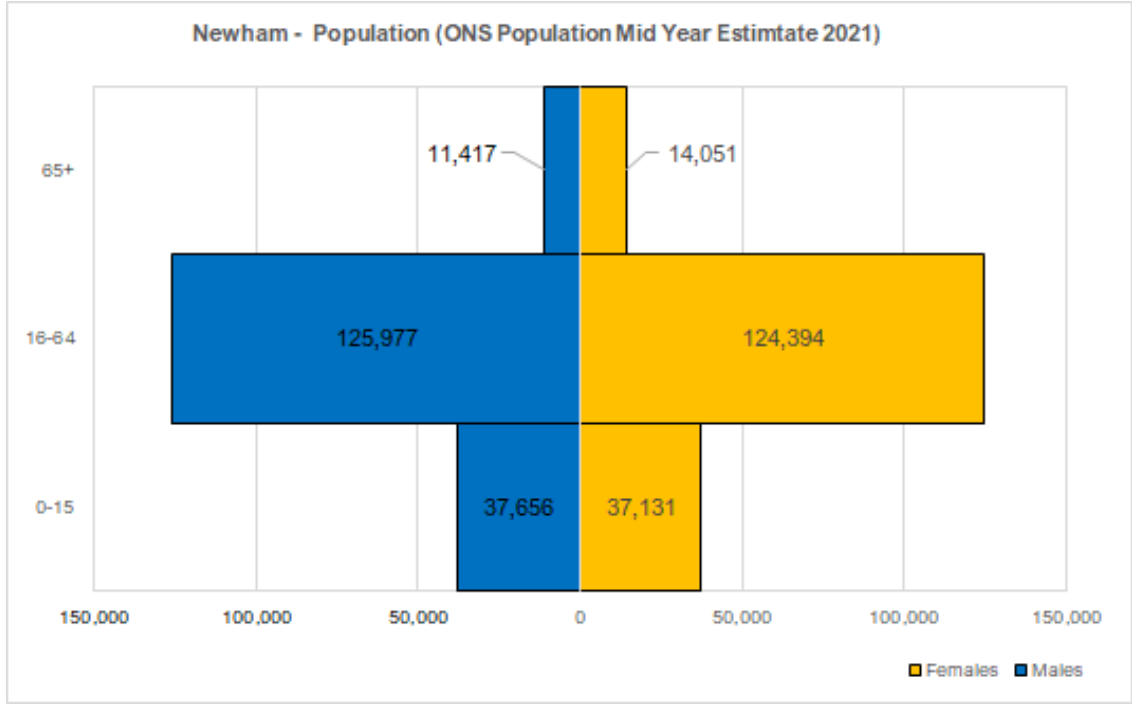
Historically unemployment numbers and rates have been reducing in Havering since April 2012

Data Source: [M01 Regional labour market: Modelled unemployment for local and unitary authorities - Office for National Statistics (ons.gov.uk)]

Newham Population – By Age Band

350,626	2021 ONS Mid year estimate population of Newham	
175,576	51.1% of the population is female	
175,050	49.9% of the population is male	
250,371		71.4% of the population Is classified as working age 16-64
124,394		70.8% of the female population Is classified as working age 16-64
125,977		72.0% of the male population Is classified as working age 16-64

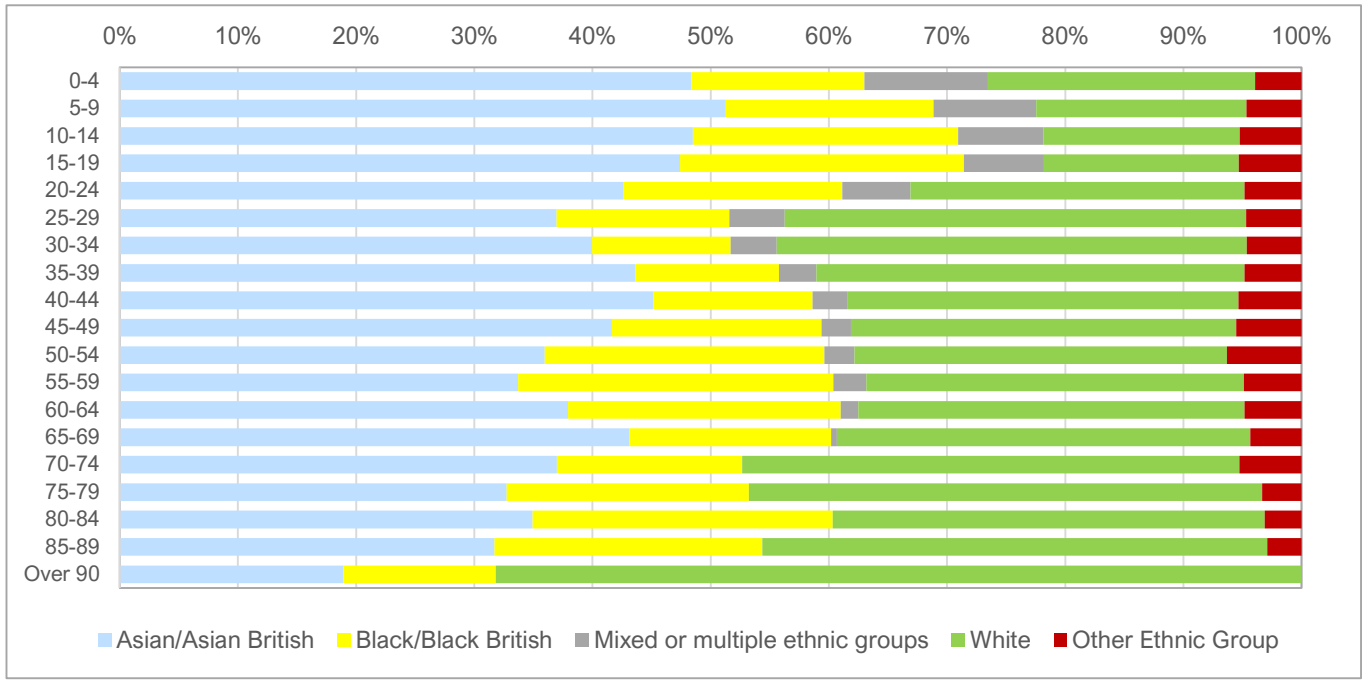


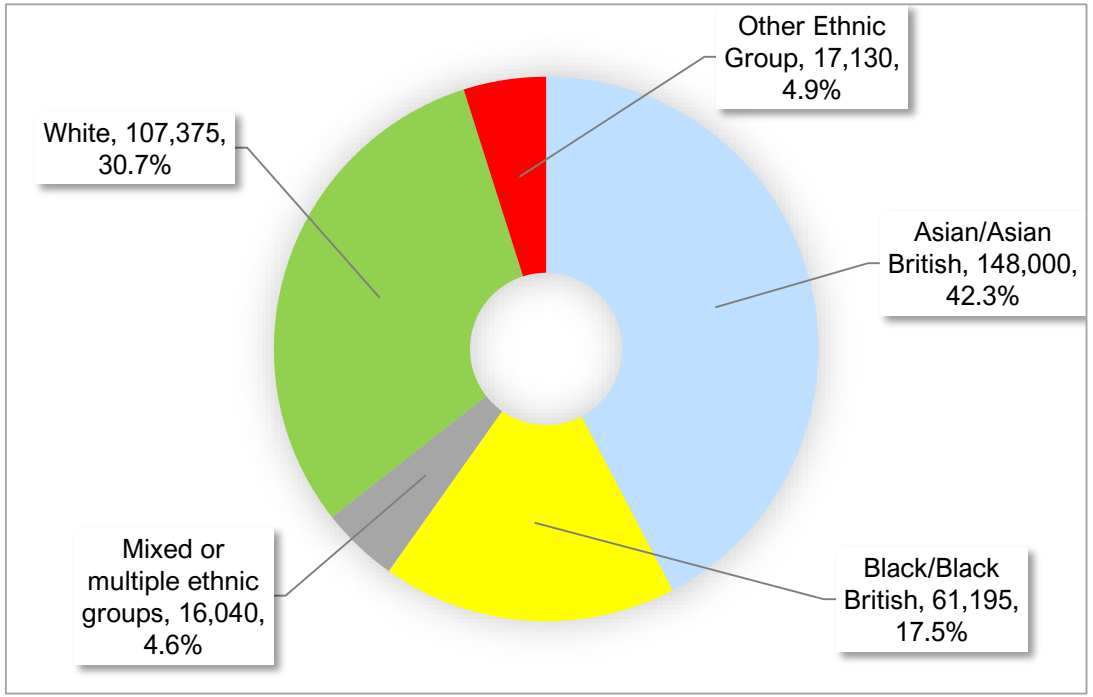


Data Source: [Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)]

Newham – Population Diversity

349,740	2021 ONS census population of Newham
148,000	**42.3%** of the population is Asian/Asian British
61,195	**17.5%** of the population is Black/Black British
16,040	**4.6%** of the population is Mixed or Multiple ethnic groups
107,375	**30.7%** of the population is White/White British
17,130	**4.9%** of the population is Other





Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Newham – Population Diversity 16 to 64

250,690

16 to 64 ONS census population of Newham

101,975

40.7% of the 16-64 population is Asian/Asian British

42,855

17.1% of the 16-64 population is Black/Black British

9,485

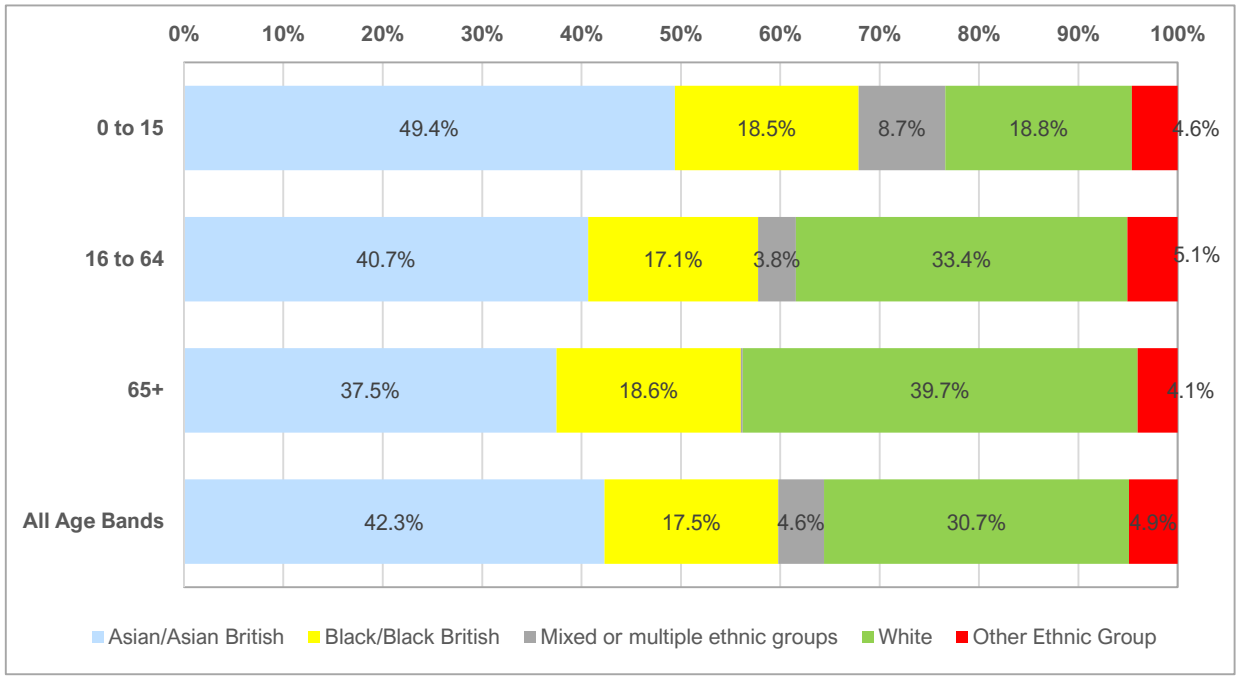
3.8% of the 16-64 population is Mixed or Multiple ethnic groups

83,675

33.4% of the 16-64 population is White/White British

12,700

5.1% of the 16-64 population is Other



Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	36,915	13,830	6,510	14,045	3,445	74,745
16 to 64	101,975	42,855	9,485	83,675	12,700	250,690
65+	9,110	4,510	45	9,655	985	24,305
All Age Bands	**148,000**	**61,195**	**16,040**	**107,375**	**17,130**	**349,740**

Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	49.4%	18.5%	8.7%	18.8%	4.6%	100%
16 to 64	40.7%	17.1%	3.8%	33.4%	5.1%	100%
65+	37.5%	18.6%	0.2%	39.7%	4.1%	100%
All Age Bands	**42.3%**	**17.5%**	**4.6%**	**30.7%**	**4.9%**	**100%**

In Newham the population is more diverse in the 0 to 15 and 16 to 64 age bands with higher proportions of all ethnic groups apart from White. As the 0 to 15 age bands move into working age the diversity of the working age population is set to increase.

Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Newham - Workforce

Primary Care Workforce – Headcount as at Jan-2023

44	**No of GP Practices in Newham**		
507	GPs	182	Nurses
270	Other Healthcare Professional	1,100	Admin- Clinical Support

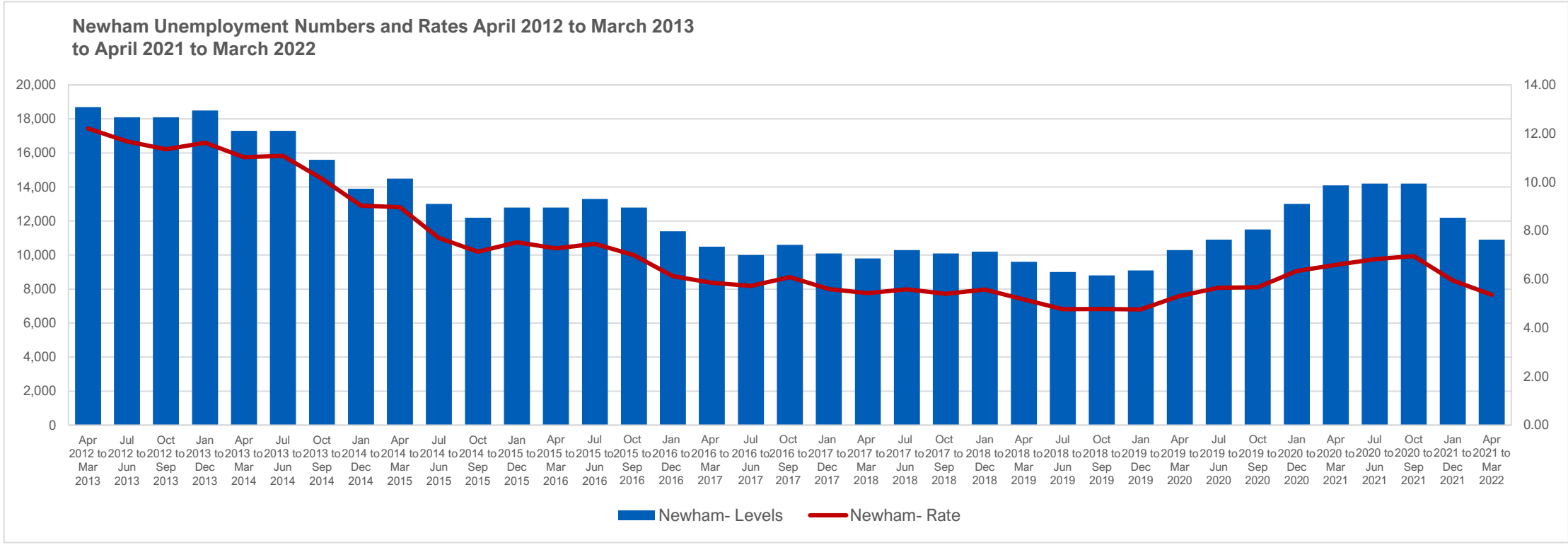
Residential Care Home Workforce – Headcount as at Feb-2023

23	**No of Residential Care Homes in Newham**
45	Nurses, 97.8% substantive, 2.2% Agency
551	Care Workers, 93.6% substantive, 6.4% Agency
104	Non Care Workers, 99.0% substantive, 1.0% Agency

Newham Population – Unemployment Figures

10,900 Unemployed in Newham as at April 2021 to March 2022

Unemployment Rate **5.4** as at April 2021 to March 2022



Historically unemployment numbers and rates have been reducing in Newham since April 2012

Data Source: [M01 Regional labour market: Modelled unemployment for local and unitary authorities - Office for National Statistics (ons.gov.uk)]

Redbridge Population – By Age Band

309,836

2021 ONS Mid year estimate population of Redbridge

156,698

50.6% of the population is female

153,138

49.4% of the population is male

203,599

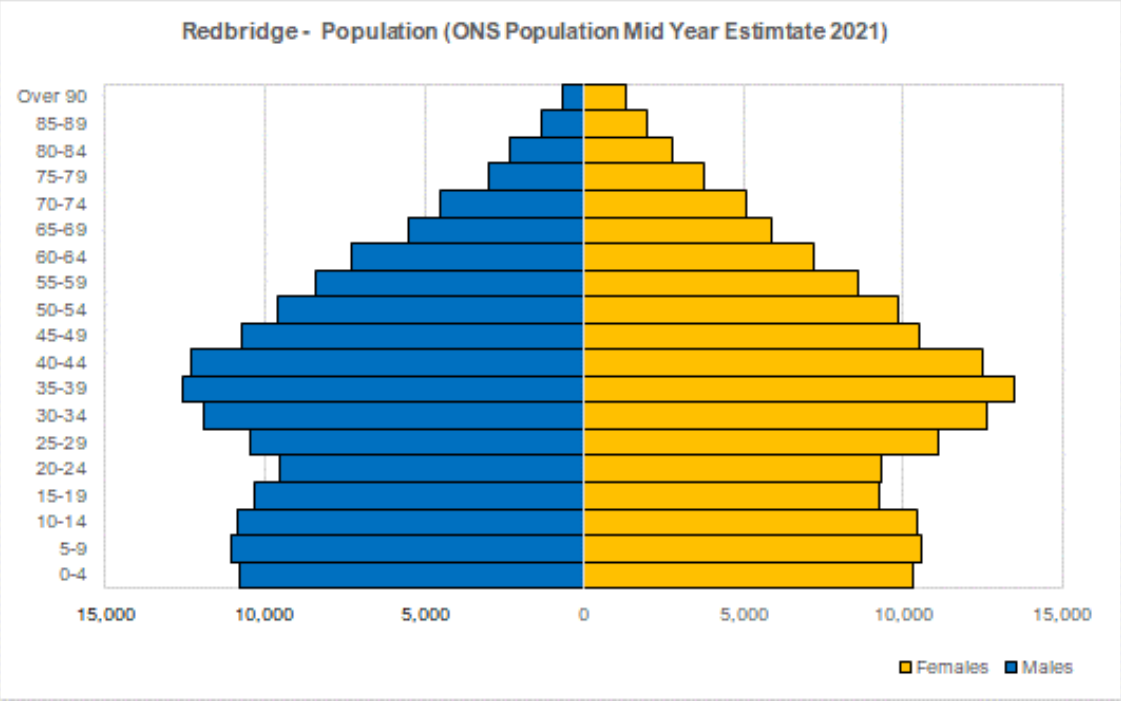
65.7% of the population Is classified as working age 16-64

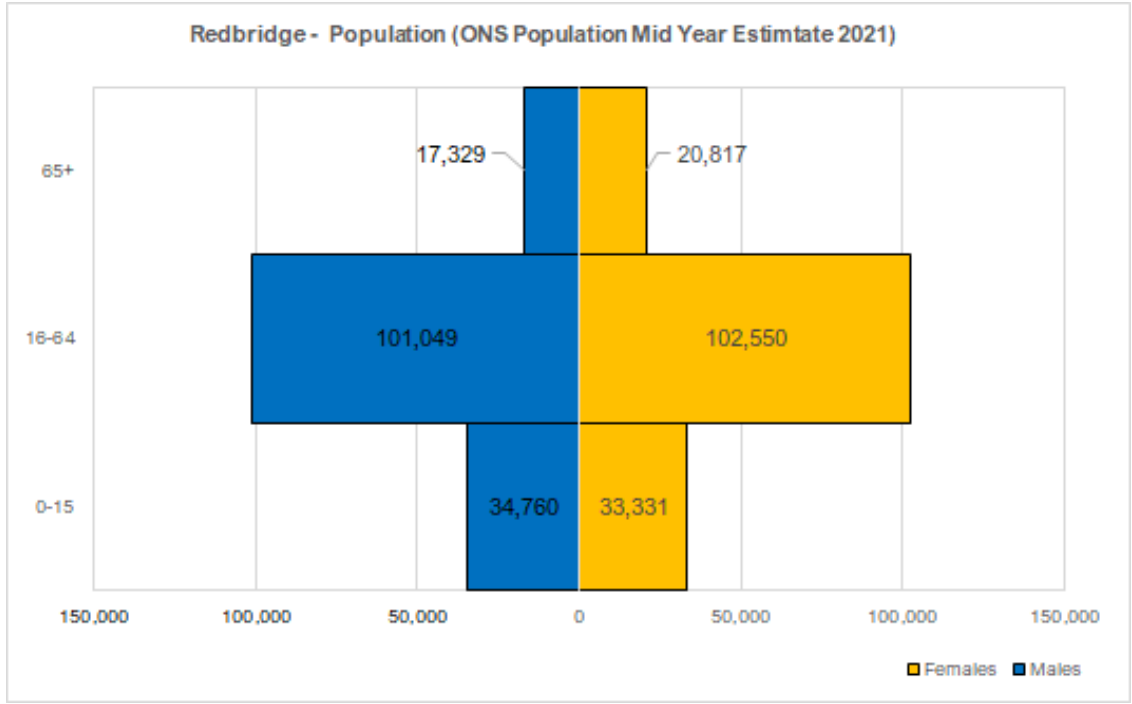
102,550

65.4% of the female population Is classified as working age 16-64

101,049

66.0% of the male population Is classified as working age 16-64





Data Source: [Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)]

Redbridge – Population Diversity

308,890

2021 ONS census population of Redbridge

146,695

47.5% of the population is Asian/Asian British

25,885

8.4% of the population is Black/Black British

12,300

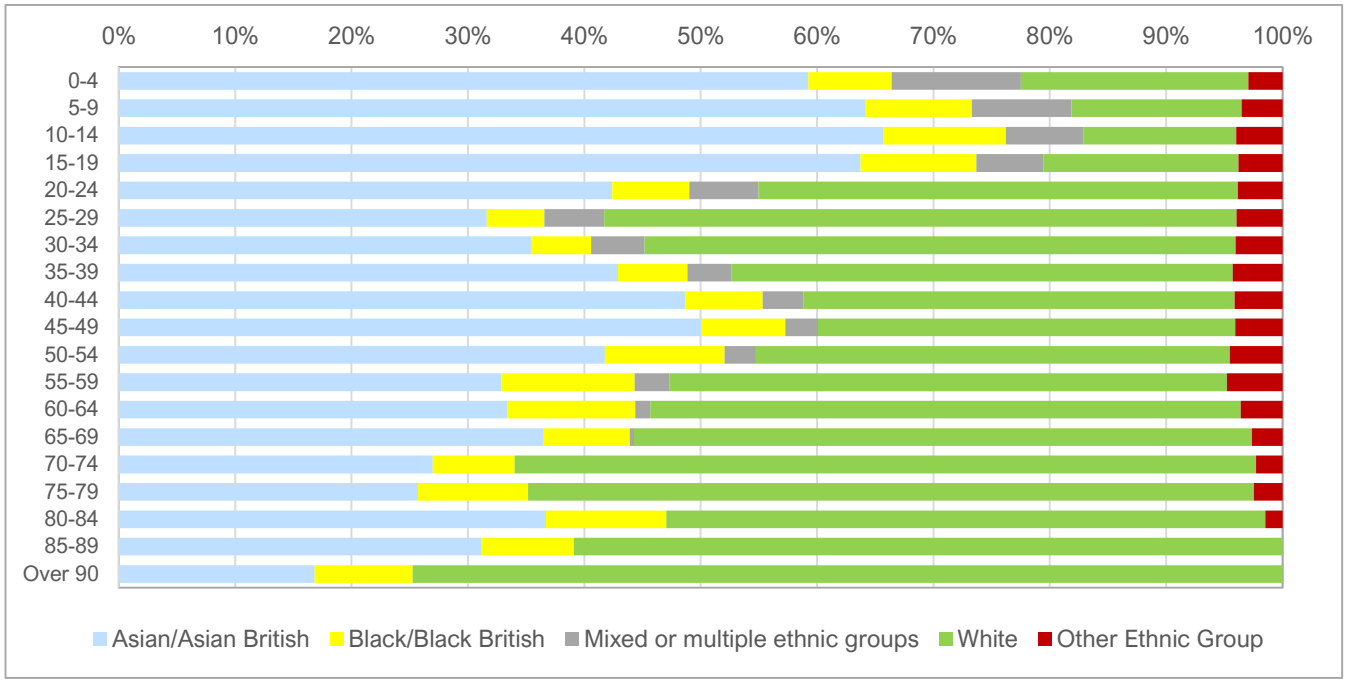
4.0% of the population is Mixed or Multiple ethnic groups

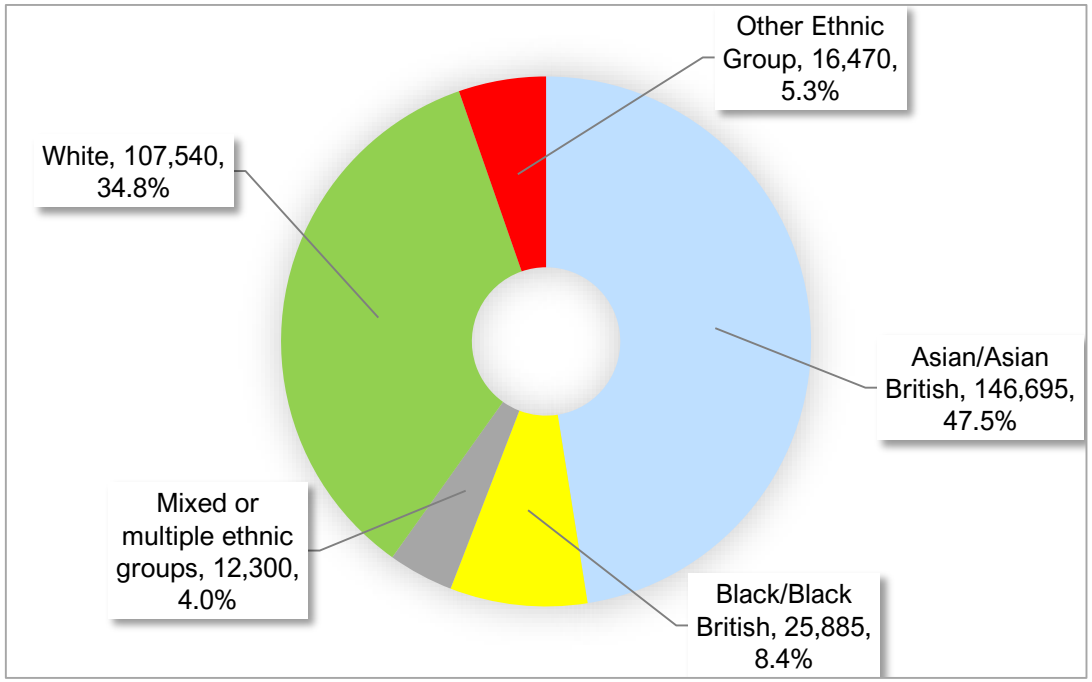
107,540

34.8% of the population is White/White British

16,470

5.3% of the population is Other





Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Redbridge – Population Diversity 16 to 64

203,670

16 to 64 ONS census population of Redbridge

97,865

48.1% of the 16-64 population is Asian/Asian British

18,150

8.9% of the 16-64 population is Black/Black British

6,380

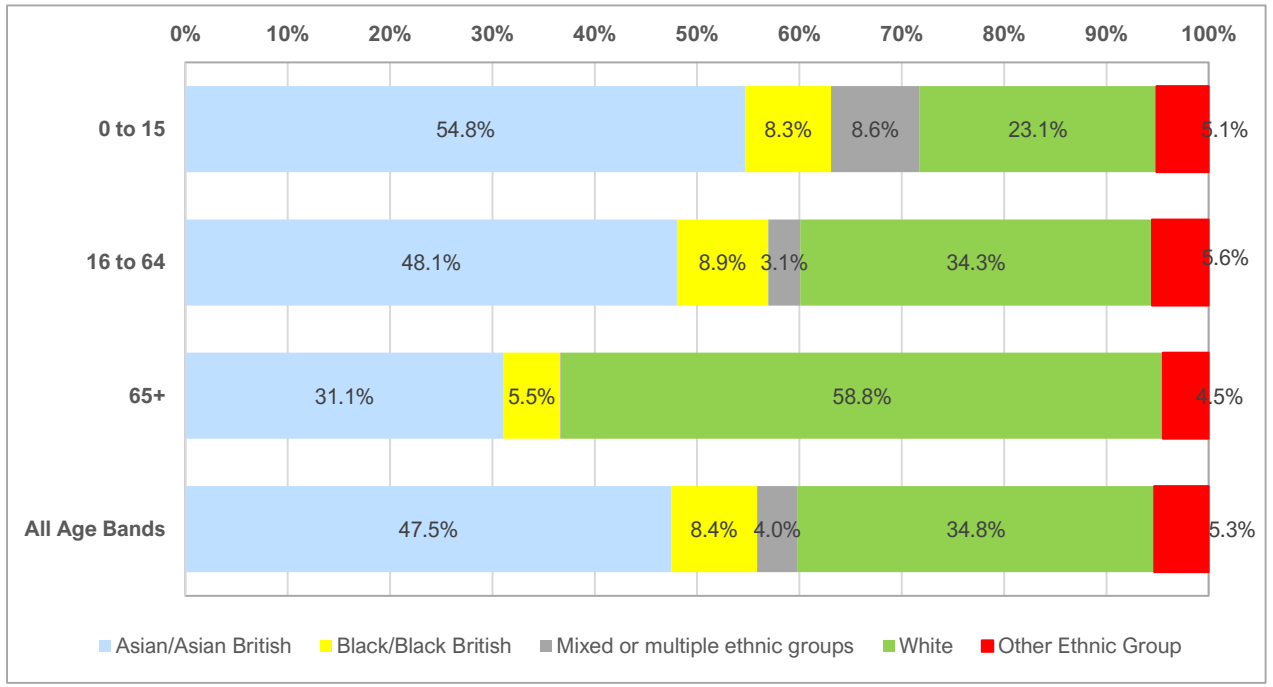
3.1% of the 16-64 population is Mixed or Multiple ethnic groups

69,955

34.3% of the 16-64 population is White/White British

11,320

5.6% of the 16-64 population is Other



Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	37,290	5,680	5,890	15,755	3,490	68,105
16 to 64	97,865	18,150	6,380	69,955	11,320	203,670
65+	11,540	2,055	30	21,830	1,660	37,115
All Age Bands	**146,695**	**25,885**	**12,300**	**107,540**	**16,470**	**308,890**

Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	54.8%	8.3%	8.6%	23.1%	5.1%	100%
16 to 64	48.1%	8.9%	3.1%	34.3%	5.6%	100%
65+	31.1%	5.5%	0.1%	58.8%	4.5%	100%
All Age Bands	**47.5%**	**8.4%**	**4.0%**	**34.8%**	**5.3%**	**100%**

In Redbridge the population is more diverse in the 0 to 15 and 16 to 64 age bands with higher proportions of all ethnic groups apart from White. As the 0 to 15 age bands move into working age the diversity of the working age population is set to increase.

Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Redbridge - Workforce

Primary Care Workforce – Headcount as at Jan-2023

43	**No of GP Practices in Redbridge**		
314	GPs	90	Nurses
102	Other Healthcare Professional	626	Admin- Clinical Support

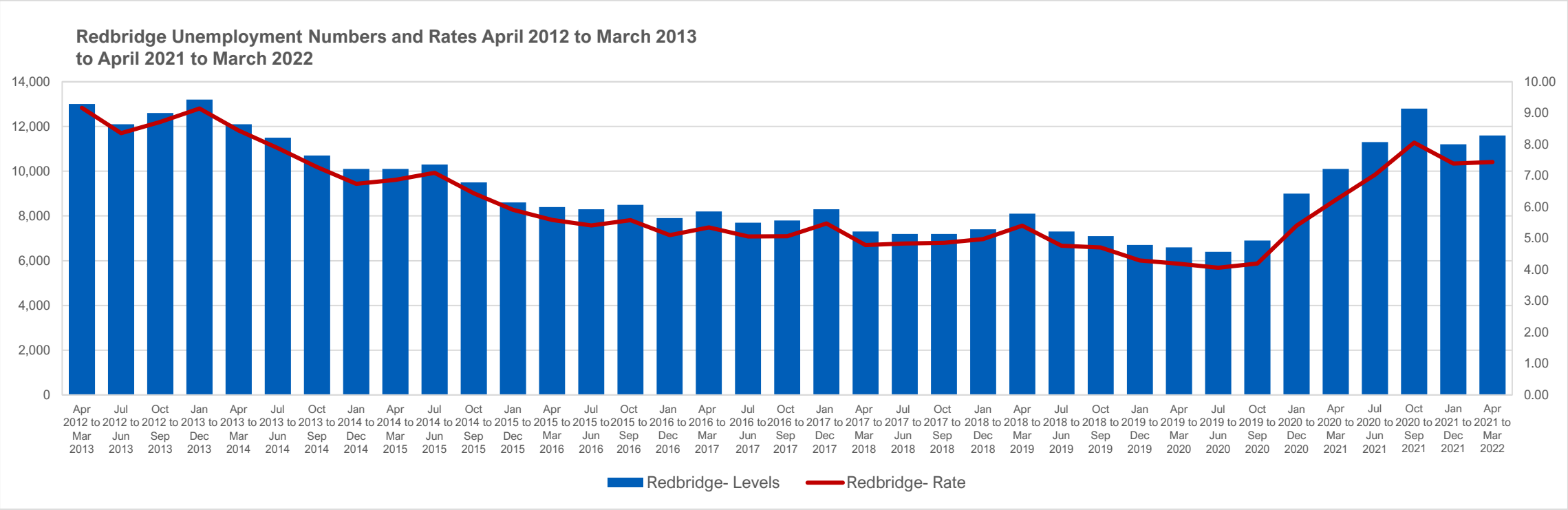
Residential Care Home Workforce – Headcount as at Feb-2023

78	**No of Residential Care Homes in Redbridge**
94	Nurses, 81.9% substantive, 18.1% Agency
1,470	Care Workers, 92.5% substantive, 7.5% Agency
363	Non Care Workers, 95.9% substantive, 4.1% Agency

Redbridge Population – Unemployment Figures

11,600 Unemployed in Redbridge as at April 2021 to March 2022

Unemployment Rate **7.4** as at April 2021 to March 2022

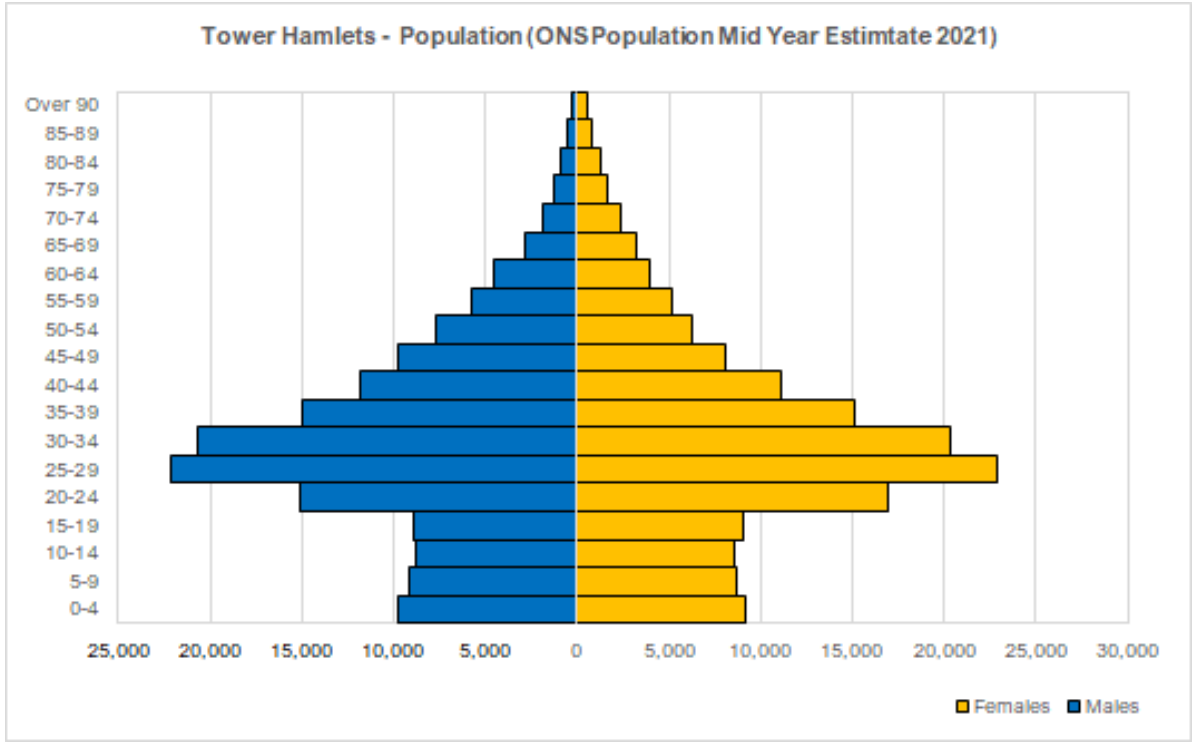


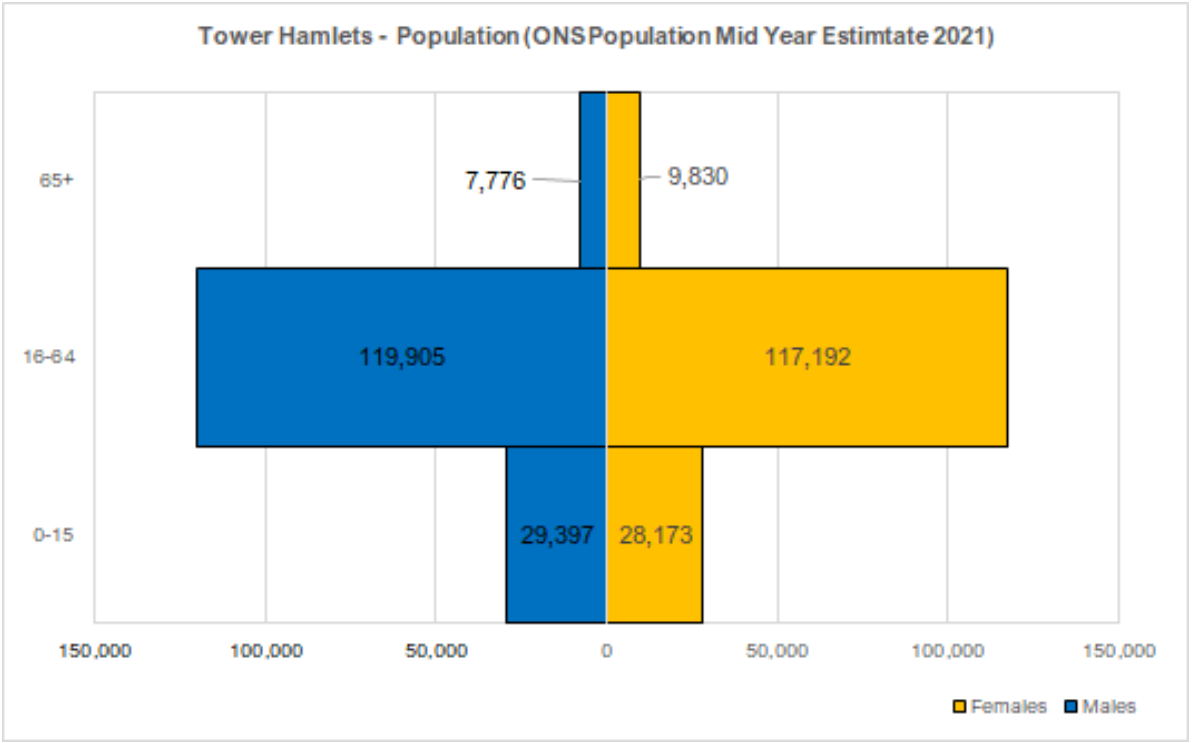
Historically unemployment numbers and rates have come down slightly in Redbridge since April 2012

Data Source: [M01 Regional labour market: Modelled unemployment for local and unitary authorities - Office for National Statistics (ons.gov.uk)]

Tower Hamlets Population – By Age Band

312,273	2021 ONS Mid year estimate population of Tower Hamlets	237,097	76.3% of the population Is classified as working age 16-64
155,195	49.7% of the population is female	117,192	75.5% of the female population Is classified as working age 16-64
157,058	50.3.% of the population is male	119,905	76.3% of the male population Is classified as working age 16-64





Data Source: [Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)]

Tower Hamlets – Population Diversity

308,815 — 2021 ONS census population of Tower Hamlets

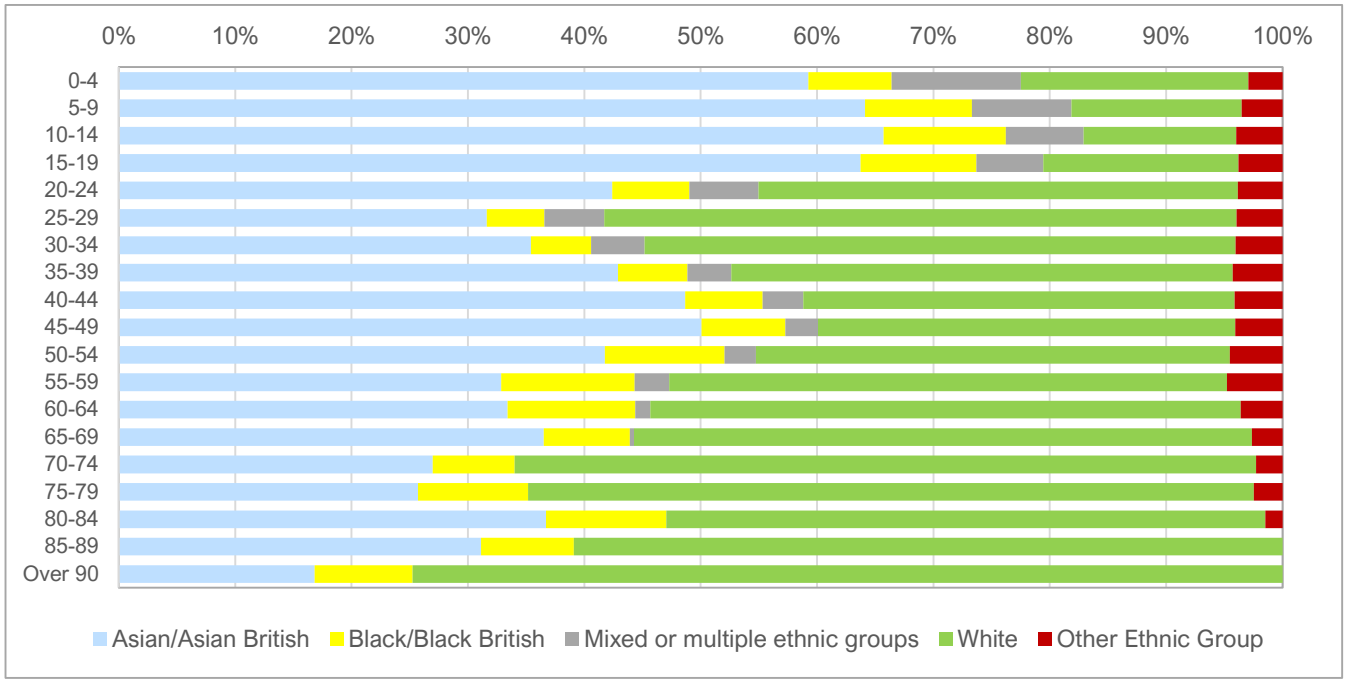
137,530 — **44.5%** of the population is Asian/Asian British

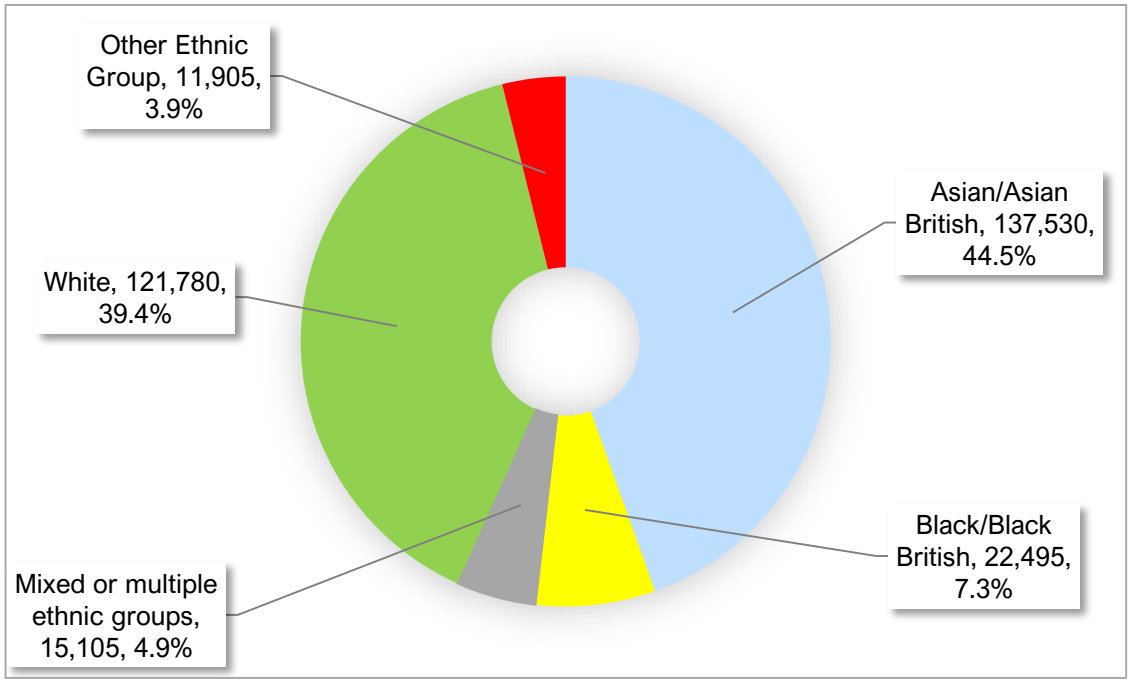
22,495 — **7.3%** of the population is Black/Black British

15,105 — **4.9%** of the population is Mixed or Multiple ethnic groups

121,780 — **39.4%** of the population is White/White British

11,905 — **3.9%** of the population is Other





Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Tower Hamlets – Population Diversity 16 to 64

235,410

16 to 64 ONS census population of Tower Hamlets

96,205

40.9% of the 16-64 population is Asian/Asian British

16.035

6.8% of the 16-64 population is Black/Black British

10,095

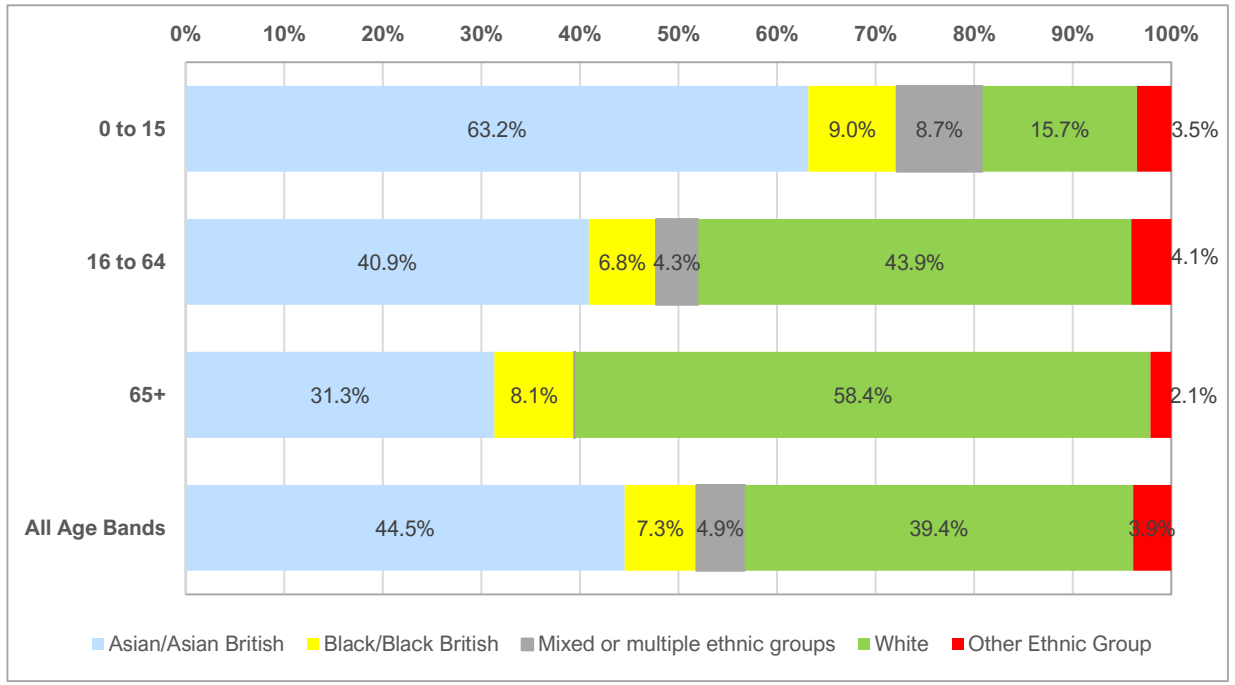
4.3% of the 16-64 population is Mixed or Multiple ethnic groups

103,240

43.9% of the 16-64 population is White/White British

9,565

4.1% of the 16-64 population is Other



Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	36,185	5,135	4,990	8,970	1,995	57,275
16 to 64	96,205	16,035	10,095	103,240	9,565	235,140
65+	5,140	1,325	20	9,570	345	16,400
All Age Bands	**137,530**	**22,495**	**15,105**	**121,780**	**11,905**	**308,815**

Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	63.2%	9.0%	8.7%	15.7%	3.5%	100%
16 to 64	40.9%	6.8%	4.3%	43.9%	4.1%	100%
65+	31.3%	8.1%	0.1%	58.4%	2.1%	100%
All Age Bands	**44.5%**	**7.3%**	**4.9%**	**39.4%**	**3.9%**	**100%**

In Tower Hamlets the population is more diverse in the 0 to 15 and 16 to 64 age bands with higher proportions of all ethnic groups apart from White. As the 0 to 15 age bands move into working age the diversity of the working age population is set to increase.

Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Tower Hamlets - Workforce

Primary Care Workforce – Headcount as at Jan-2023

36	**No of GP Practices in Tower Hamlets**
568	GPs
399	Other Healthcare Professional
5	Other
276	Nurses
666	Admin- Clinical Support

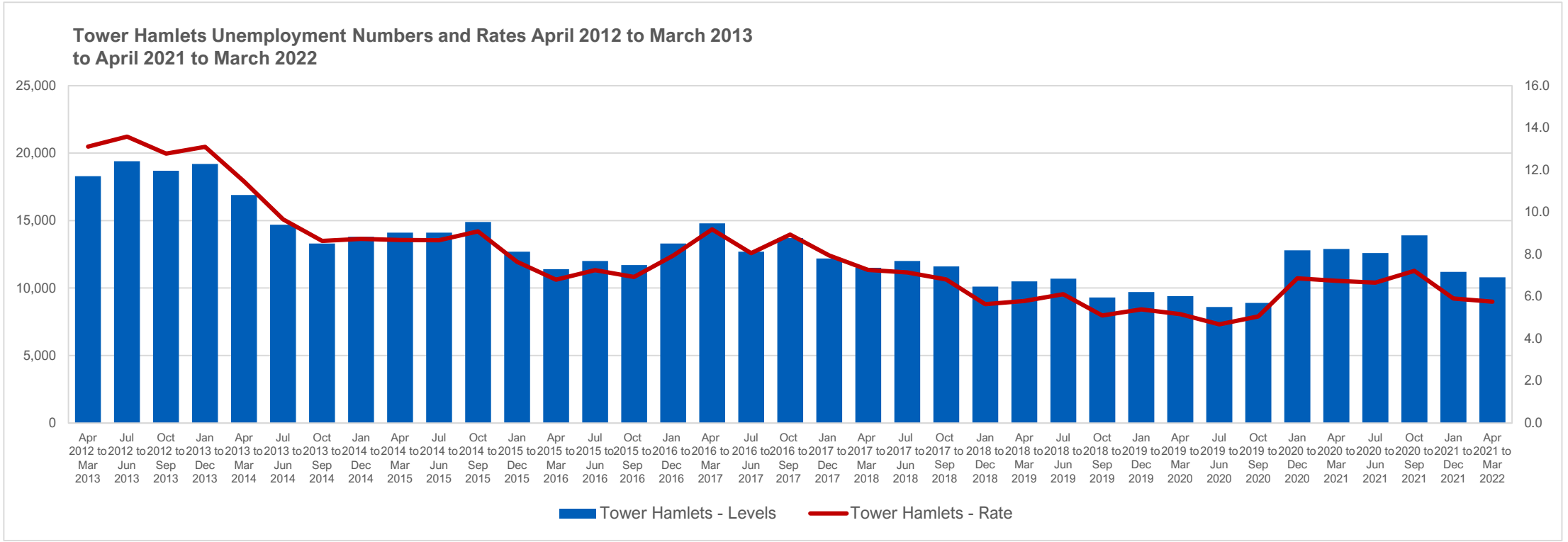
Residential Care Home Workforce – Headcount as at Feb-2023

9	**No of Residential Care Homes in Tower Hamlets**
19	Nurses, 100% substantive, 0% Agency
316	Care Workers, 94.6% substantive, 5.4% Agency
85	Non Care Workers, 100% substantive, 0% Agency

Tower Hamlets Population – Unemployment Figures

10,800 Unemployed in Tower Hamlets as at April 2021 to March 2022

Unemployment Rate **5.8** as at April 2021 to March 2022

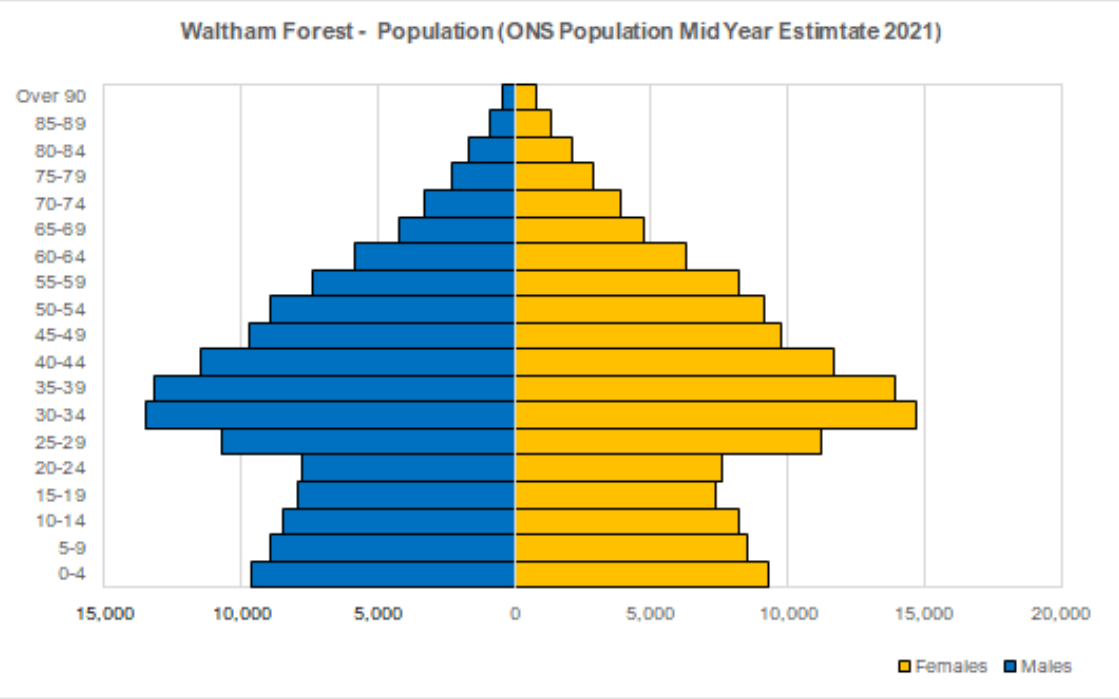


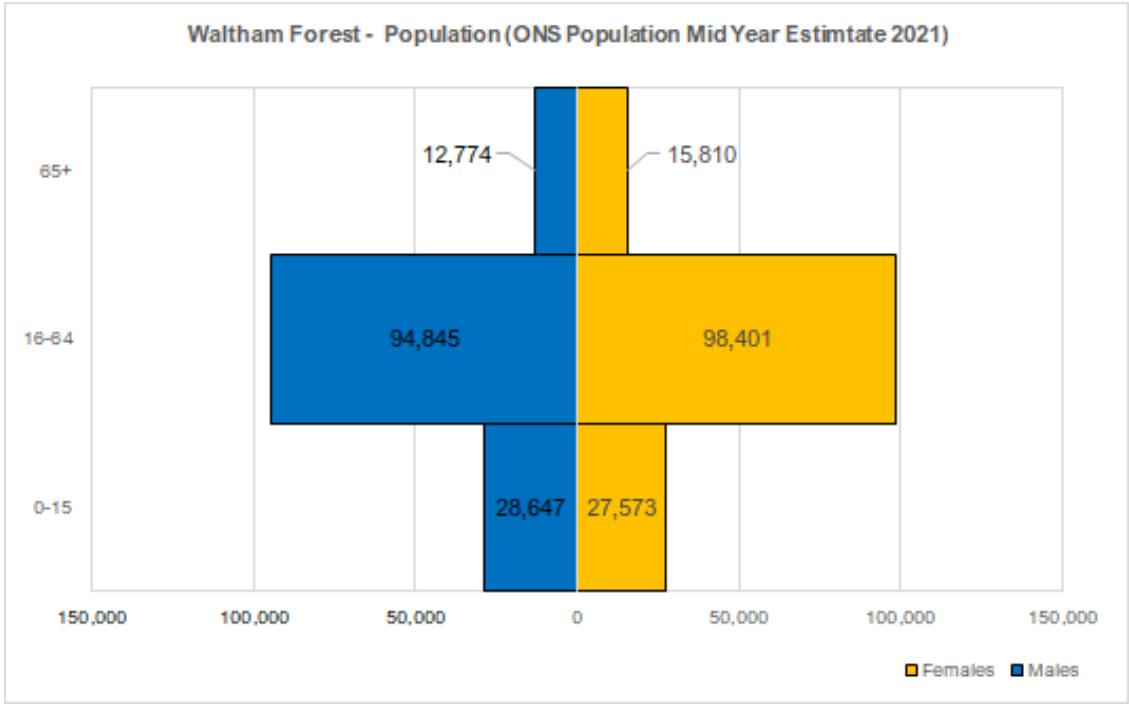
Historically unemployment numbers and rates have been reducing in Tower Hamlets since April 2012

Data Source: [M01 Regional labour market: Modelled unemployment for local and unitary authorities - Office for National Statistics (ons.gov.uk)]

Waltham Forest Population – By Age Band

	278,050	2021 ONS Mid year estimate population of Waltham Forest	193,246	69.5% of the population Is classified as working age 16-64
	141,784	51.0% of the population is female	98,401	69.4% of the female population Is classified as working age 16-64
	136,266	49.0% of the population is male	94,845	69.6% of the male population Is classified as working age 16-64





Data Source: [Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)]

Waltham Forest – Population Diversity

277,160

2021 ONS census population of Waltham Forest

55,250

19.9% of the population is Asian/Asian British

41,530

15.0% of the population is Black/Black British

17,660

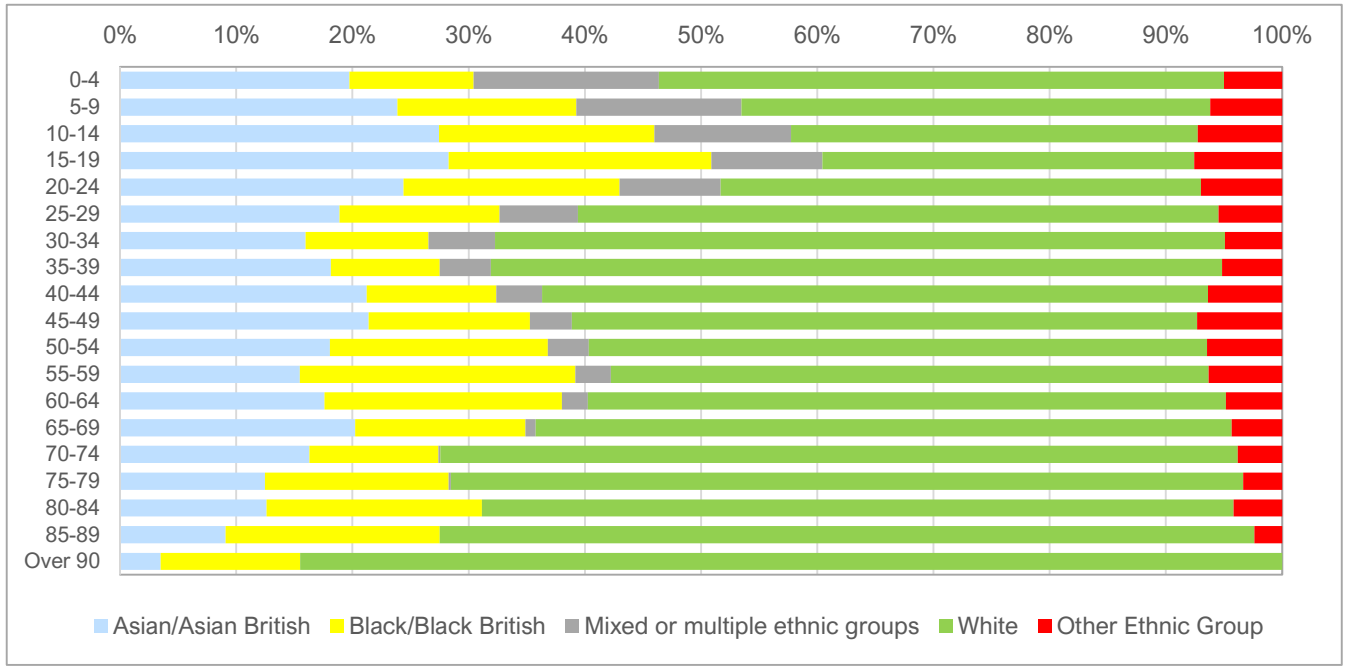
6.4% of the population is Mixed or Multiple ethnic groups

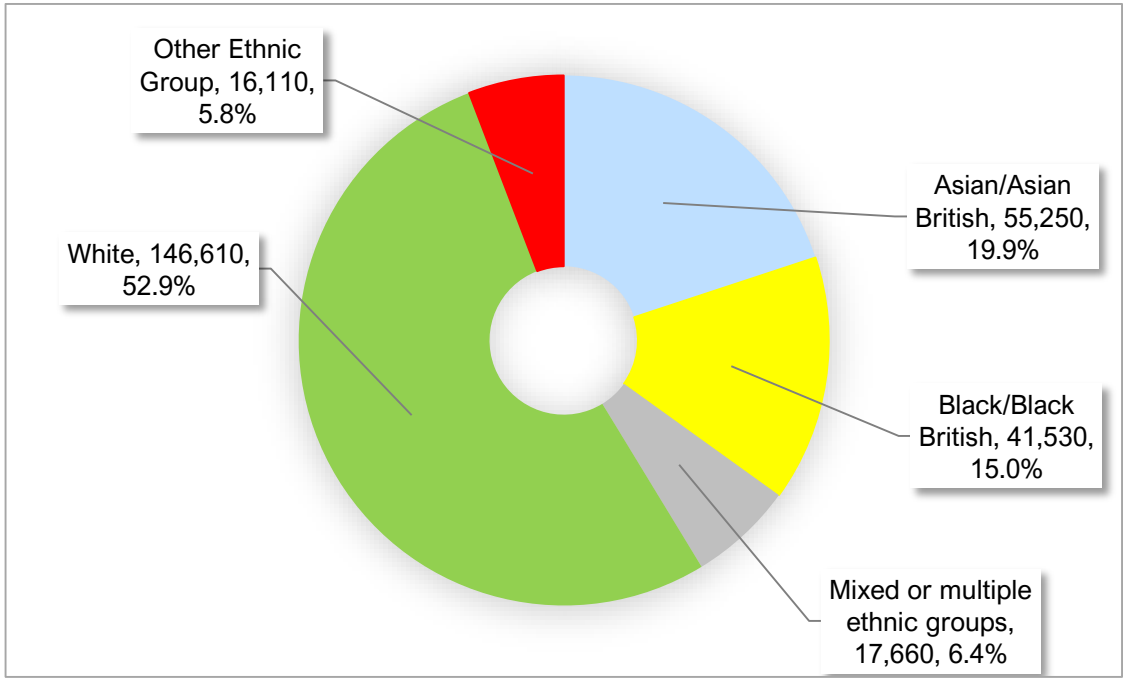
146,610

52.9% of the population is White/White British

17,660

5.8% of the population is Other





Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Waltham Forest – Population Diversity 16 to 64

193,540 — 16 to 64 ONS census population of Waltham Forest

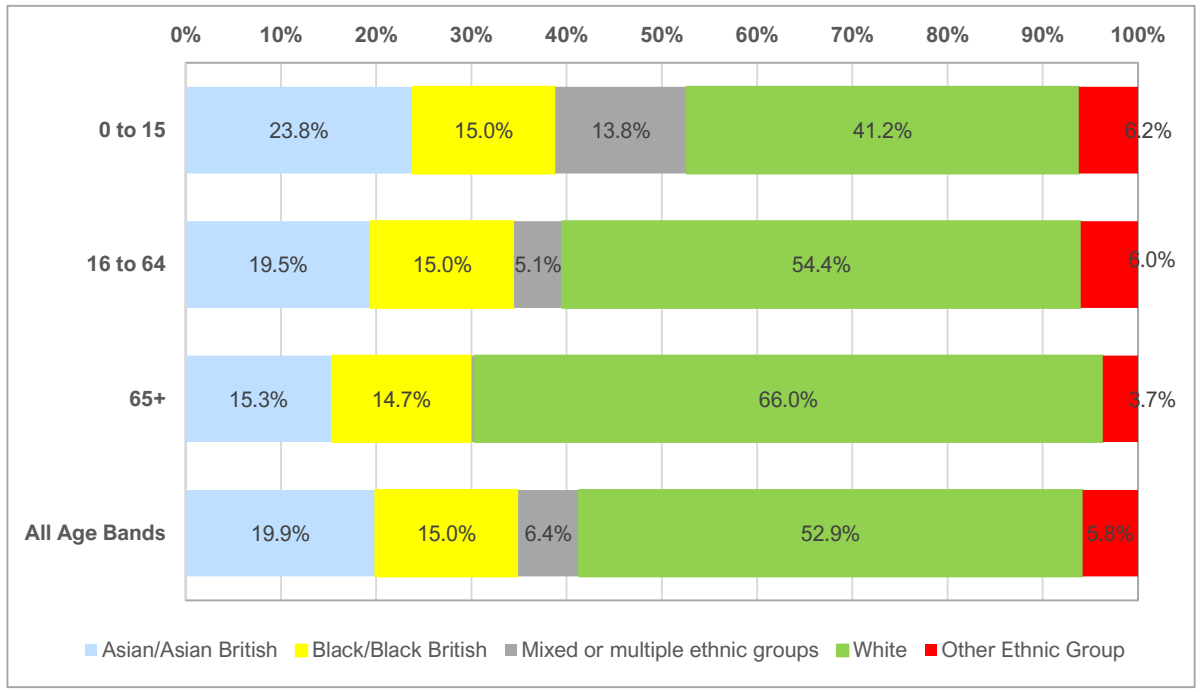
37,655 — **19.5%** of the 16-64 population is Asian/Asian British

29,085 — **15.0%** of the 16-64 population is Black/Black British

9,810 — **5.1%** of the 16-64 population is Mixed or Multiple ethnic groups

105,380 — **54.4%** of the 16-64 population is White/White British

11,610 — **6.0%** of the 16-64 population is Other



Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	13,380	8,415	7,755	23,105	3,485	56,140
16 to 64	37,655	29,085	9,810	105,380	11,610	193,540
65+	4,215	4,030	95	18,125	1,015	27,480
All Age Bands	**55,250**	**41,530**	**17,660**	**146,610**	**16,110**	**277,160**

Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	23.8%	15.0%	13.8%	41.2%	6.2%	100%
16 to 64	19.5%	15.0%	5.1%	54.4%	6.0%	100%
65+	15.3%	14.7%	0.3%	66.0%	3.7%	100%
All Age Bands	**19.9%**	**15.0%**	**6.4%**	**52.9%**	**5.8%**	**100%**

In Waltham Forest the population is more diverse in the 0 to15 and 16 to 64 age bands with higher proportions of all ethnic groups apart from White. As the 0 to 15 age bands move into working age the diversity of the working age population is set to increase.

Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Waltham Forest - Workforce

Primary Care Workforce – Headcount as at Jan-2023

39	**No of GP Practices in Waltham Forest**		
436	GPs	134	Nurses
74	Other Healthcare Professional	836	Admin- Clinical Support

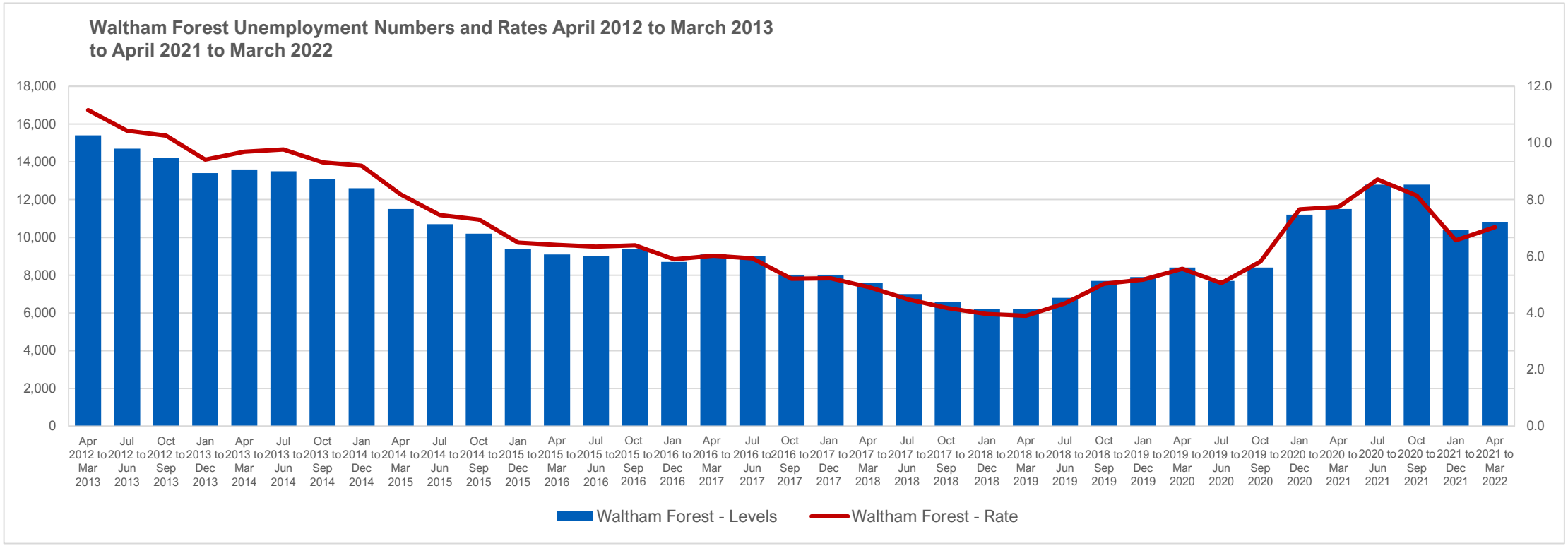
Residential Care Home Workforce – Headcount as at Feb-2023

46	**No of Residential Care Homes in Waltham Forest**
43	Nurses, 90.7% substantive, 9.3% Agency
896	Care Workers, 89.7% substantive, 10.3% Agency
229	Non Care Workers, 96.5% substantive, 3.5% Agency

Waltham Forest Population – Unemployment Figures

10,800 Unemployed in Waltham Forest as at April 2021 to March 2022

Unemployment Rate **7.0** as at April 2021 to March 2022

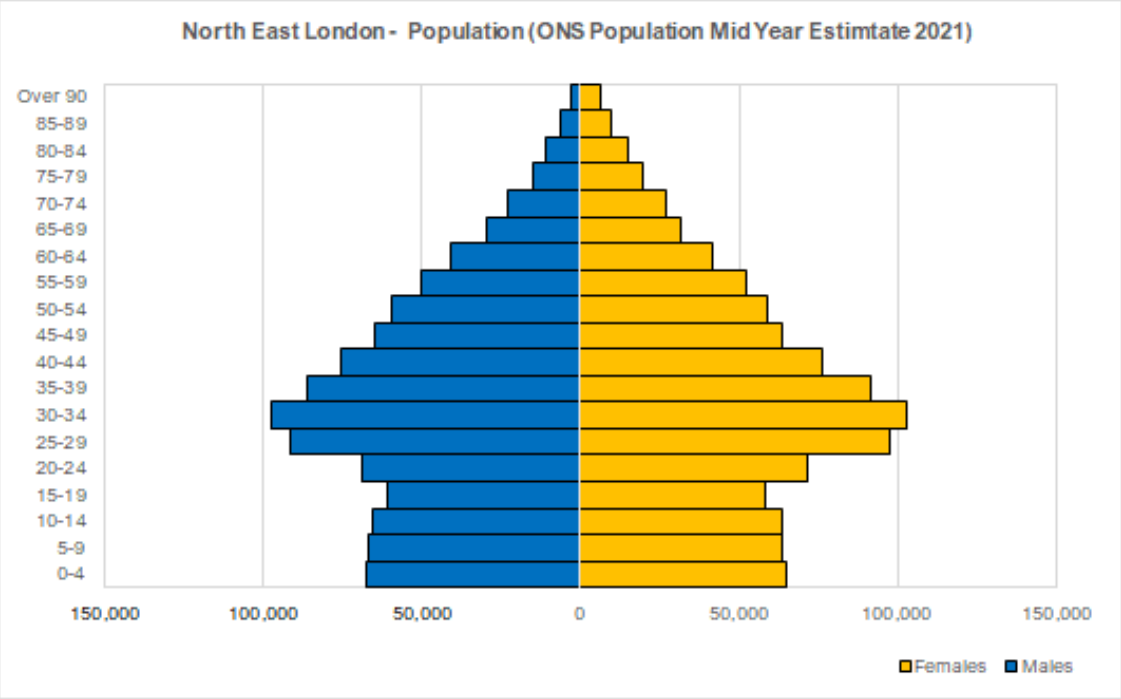


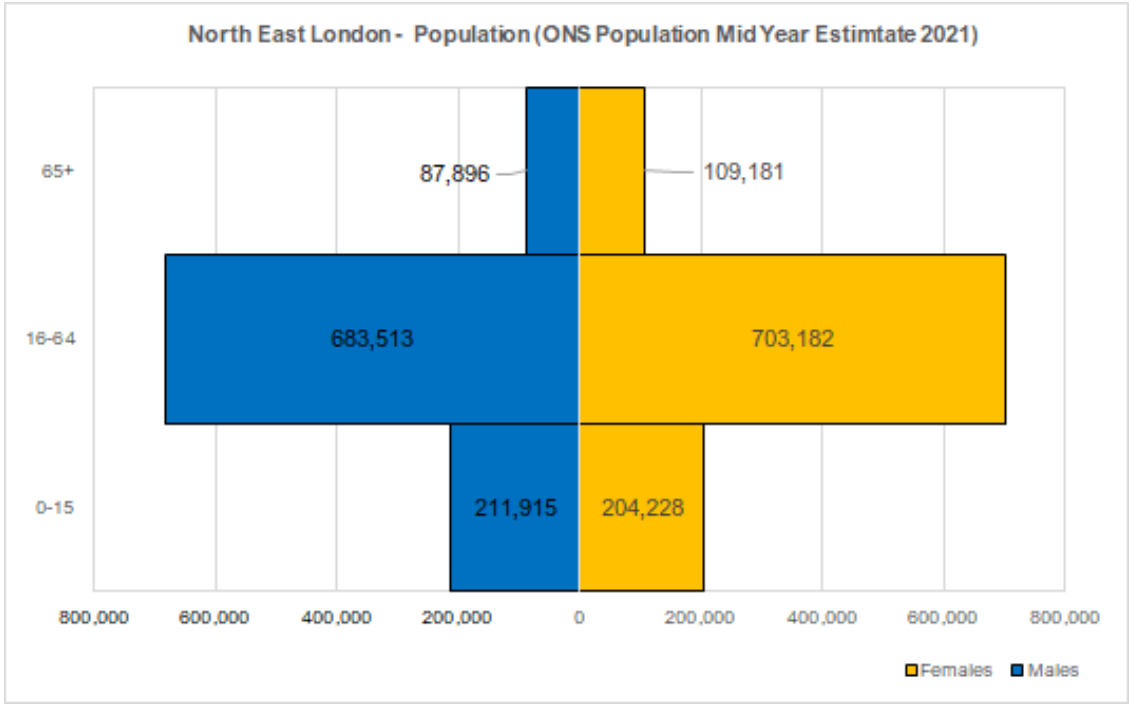
Historically unemployment numbers and rates have come down in Waltham Forest since April 2012

Data Source: [M01 Regional labour market: Modelled unemployment for local and unitary authorities - Office for National Statistics (ons.gov.uk)]

North East London Population – By Age Band

	1,999,915	2021 ONS Mid year estimate population of North East London	1,386,695	69.3% of the population Is classified as working age 16-64
	1,016,591	50.8% of the population is female	703,182	69.2% of the female population Is classified as working age 16-64
	983,324	49.2% of the population is male	683,513	69.5% of the male population Is classified as working age 16-64





Data Source: [Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)]

North East London – Population Diversity

1,979,670

2021 ONS census population of North East London

598,090

30.2% of the population is Asian/Asian British

273,600

13.8% of the population is Black/Black British

96,465

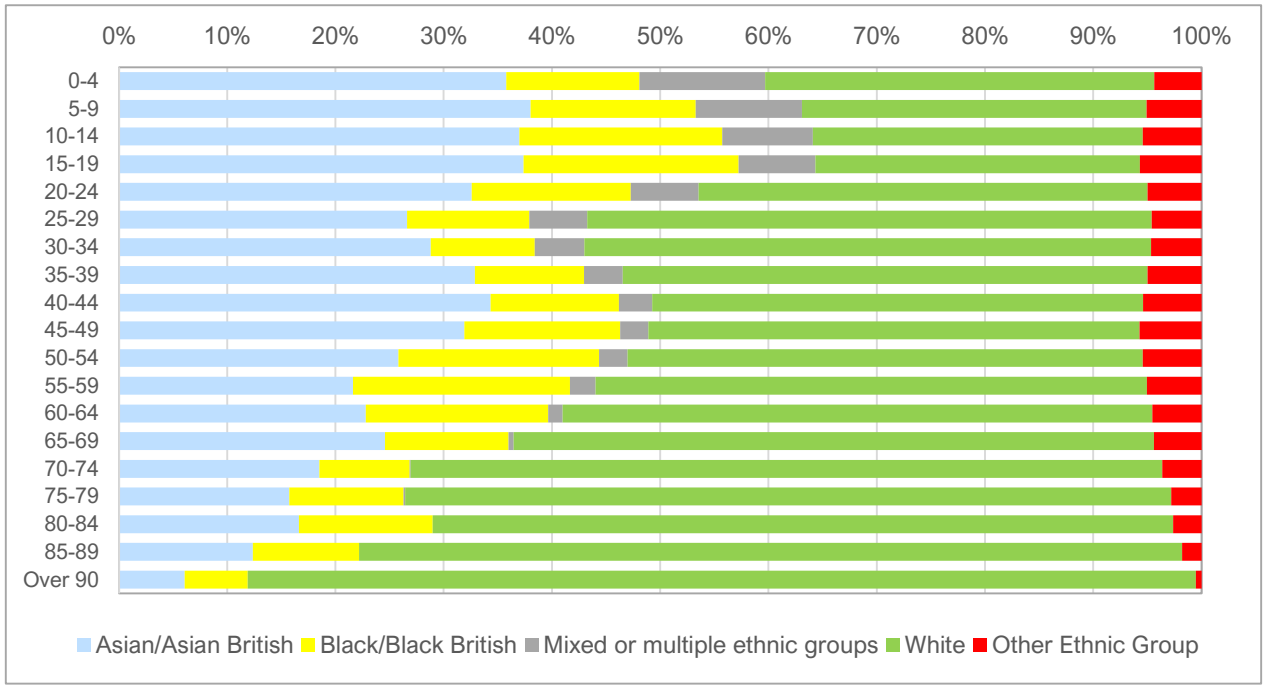
4.9% of the population is Mixed or Multiple ethnic groups

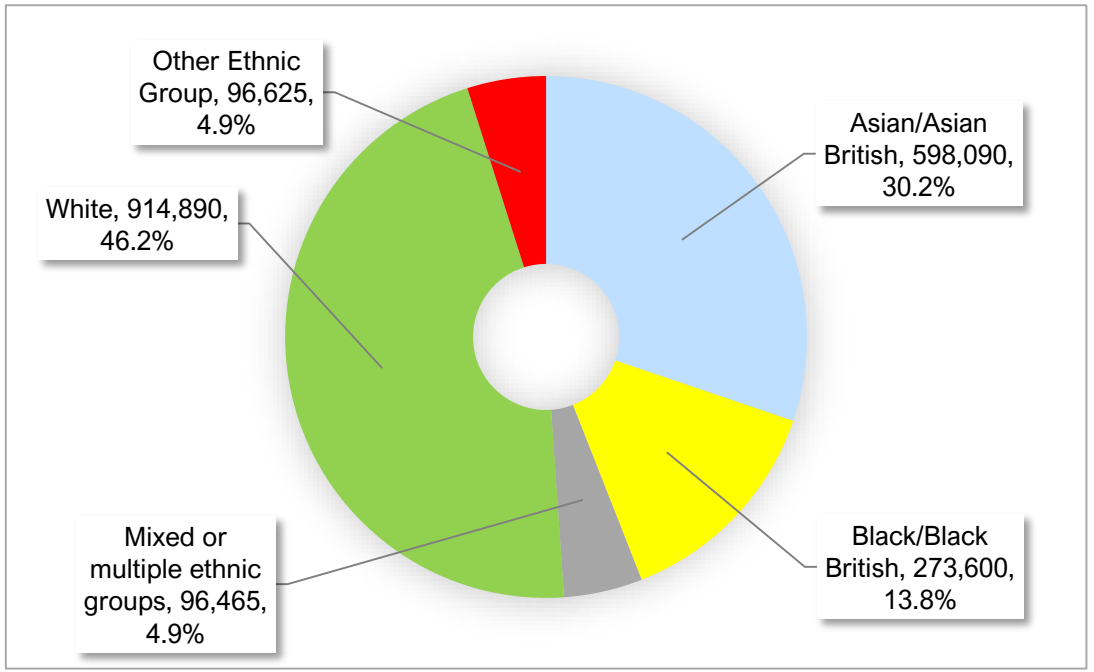
914,890

46.2% of the population is White/White British

96,625

4.9% of the population is Other





Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

North East London – Population Diversity 16 to 64

1,376,490

16 to 64 ONS census population of North East London

409,680

29.8% of the 16-64 population is Asian/Asian British

189,315

13.8% of the 16-64 population is Black/Black British

55,350

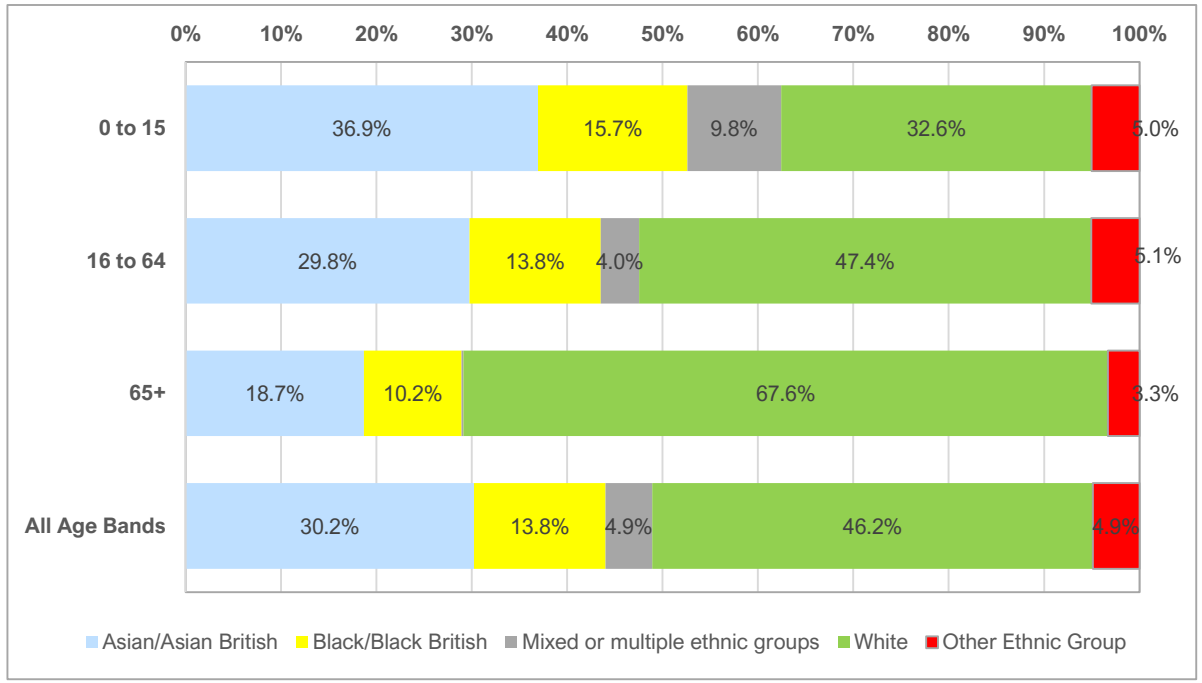
4.0% of the 16-64 population is Mixed or Multiple ethnic groups

652,530

47.4% of the 16-64 population is White/White British

69,615

5.1% of the 16-64 population is Other



Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	153,200	65,010	40,745	135,100	20,765	414,820
16 to 64	409,680	189,315	55,350	652,530	69,615	1,376,490
65+	35,210	19,275	370	127,260	6,245	188,360
All Age Bands	**598,090**	**273,600**	**96,465**	**914,890**	**96,625**	**1,979,670**

Age Band	Asian/Asian British	Black/Black British	Mixed or multiple ethnic groups	White	Other Ethnic Group	Total
0 to 15	36.9%	15.7%	9.8%	32.6%	5.0%	100%
16 to 64	29.8%	13.8%	4.0%	47.4%	5.1%	100%
65+	18.7%	10.2%	0.2%	67.6%	3.3%	100%
All Age Bands	**30.2%**	**13.8%**	**4.9%**	**46.2%**	**4.9%**	**100%**

In North East London the population is more diverse in the 0 to15 and 16 to 64 age bands with higher proportions of all ethnic groups apart from White. As the 0 to 15 age bands move into working age the diversity of the working age population is set to increase.

Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

North East London – Population Diversity Comparisons

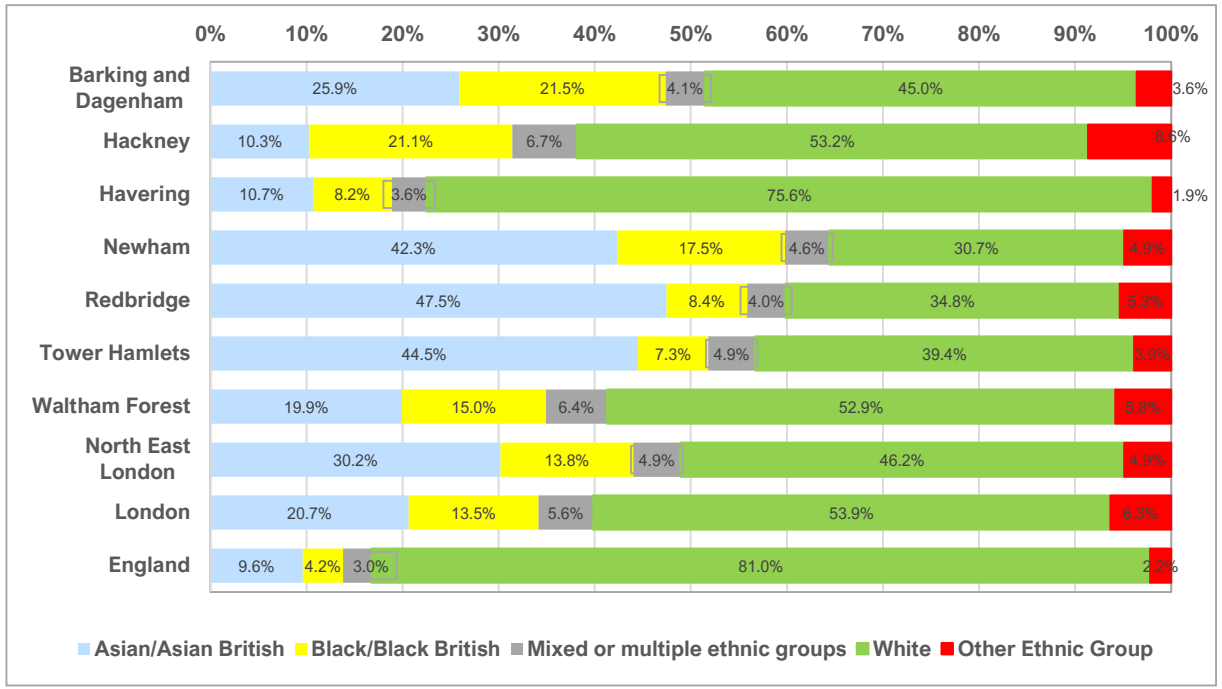
53.8% of **North East London's** population are from Ethnic Minorities

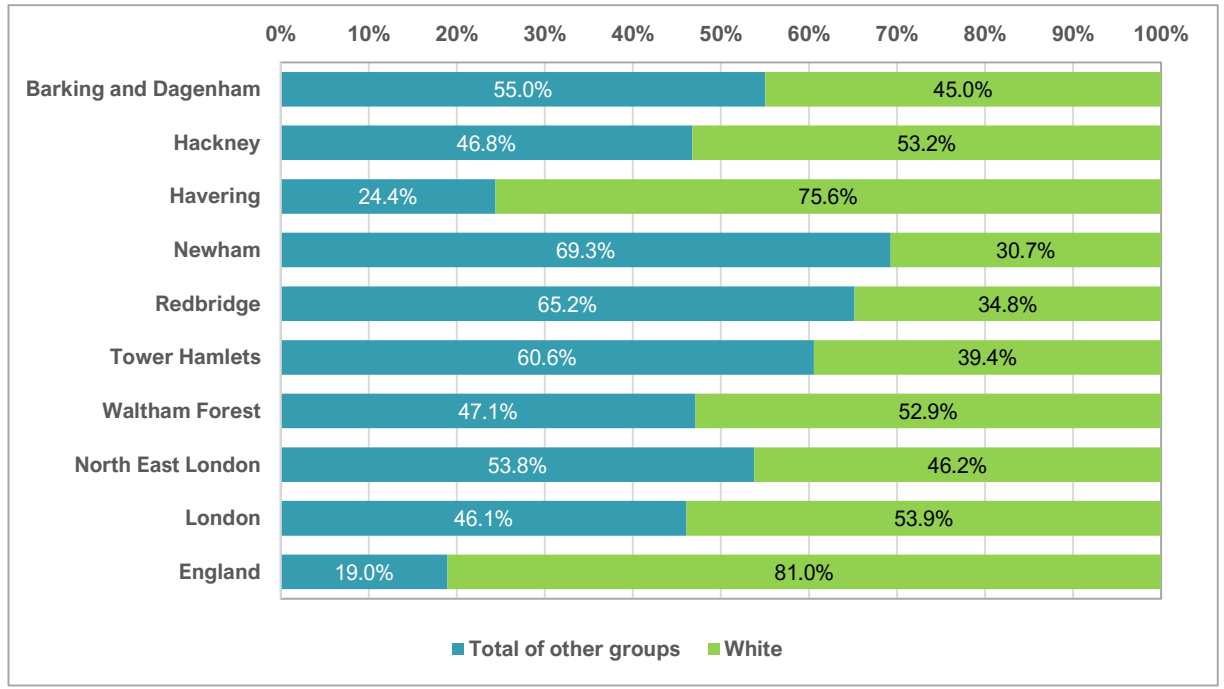
69.3% of **Newham's** population are from Ethnic Minorities

46.1% of **London's** population are from Ethnic Minorities

19.0% of **England's** population are from Ethnic Minorities

North East London has one of the most diverse populations in England





Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

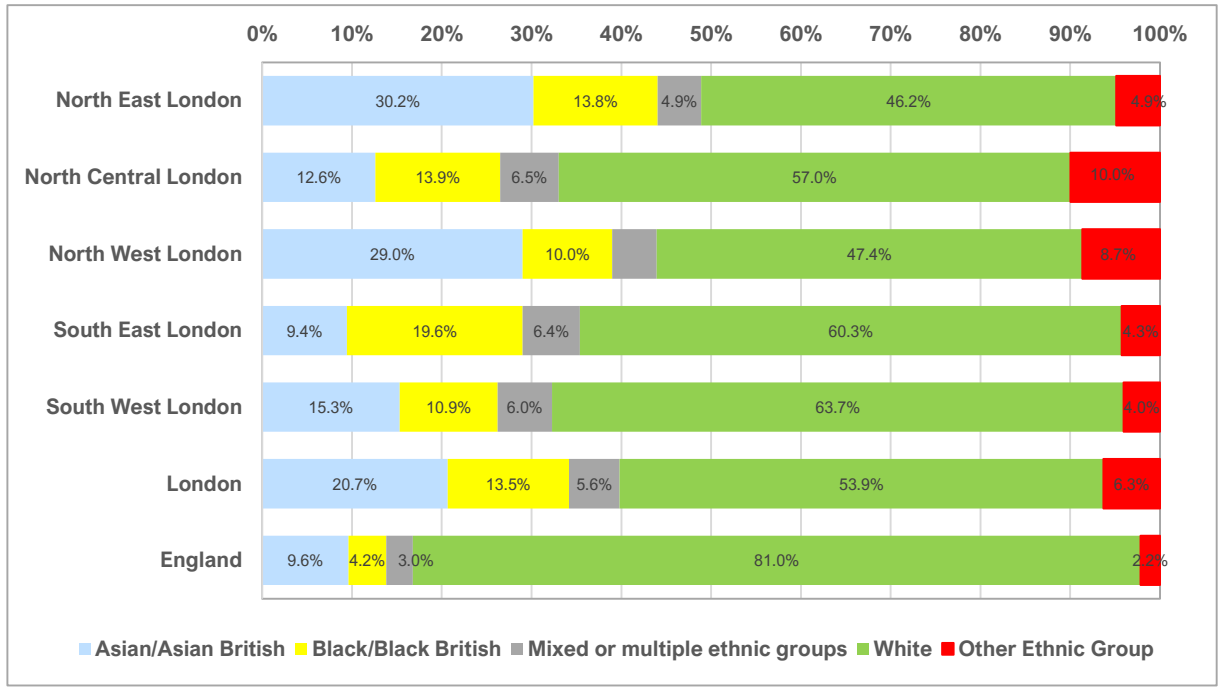
North East London – Population Diversity London Comparisons

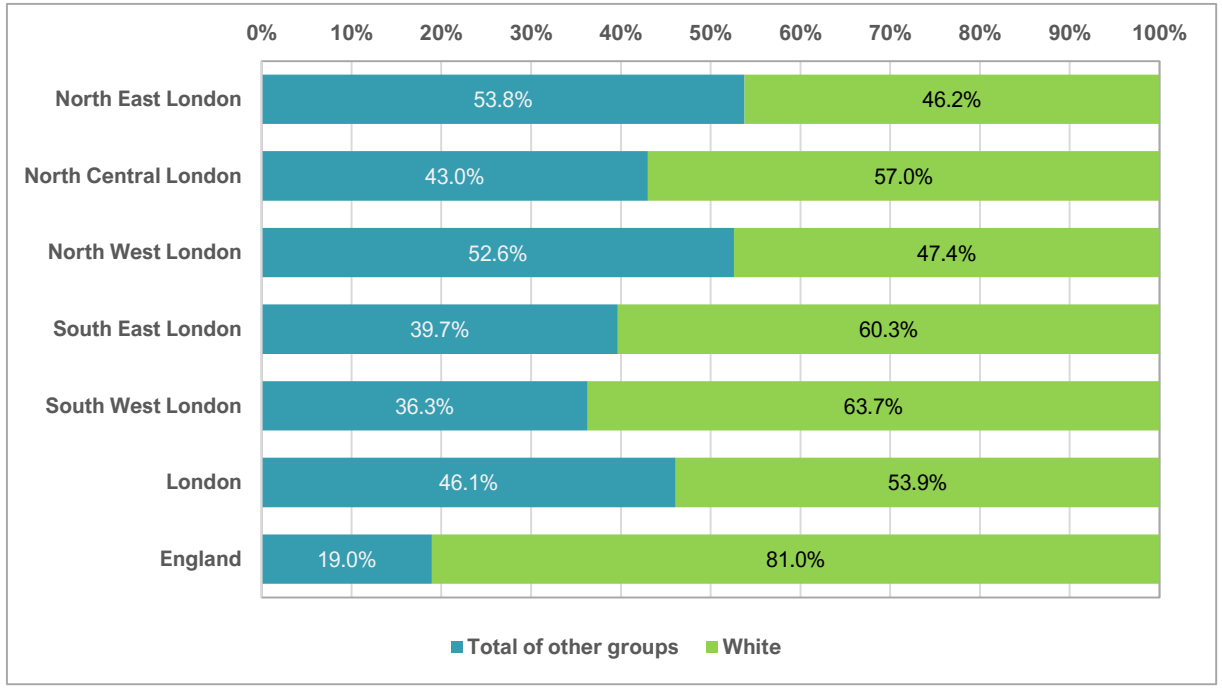
53.8% of **North East London's** population are from Ethnic Minorities

46.1% of **London's** population are from Ethnic Minorities

19.0% of **England's** population are from Ethnic Minorities

North East London has the most diverse population in London and one of the most diverse populations in England





Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

North East London - Workforce

Primary Care Workforce – Headcount as at Jan-2023

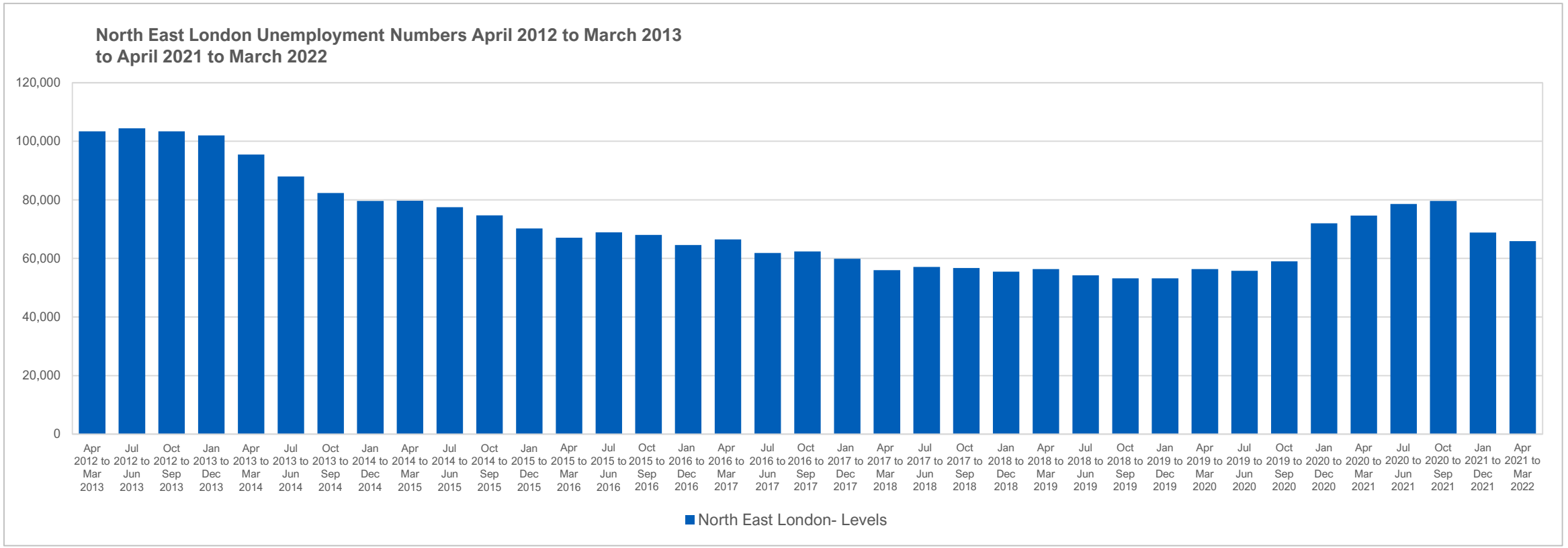
269	**No of GP Practices in North East London**		
3,128	GPs	1,016	Nurses
1,032	Other Healthcare Professional	6,124	Admin- Clinical Support

Residential Care Home Workforce – Headcount as at Feb-2023

248	**No of Residential Care Homes in North East London**
559	Nurses, 88.2% substantive, 11.8% Agency
5,951	Care Workers, 91.6% substantive, 8.4% Agency
1,582	Non Care Workers, 95.1% substantive, 4.9% Agency

North East London Population – Unemployment Figures

65,900 Unemployed in North East London as at April 2021 to March 2022



Historically unemployment numbers have come down in North East London since April 2012

Data Source: M01 Regional labour market: Modelled unemployment for local and unitary authorities - Office for National Statistics (ons.gov.uk)

North East London Average population per GP Practice

Borough	Number of GP practices	ONS 2021 MYE Population	Average Population per GP Practice	Rank Across NEL
Barking and Dagenham	33	218,534	6,622	6
City and Hackney	39	268,574	6,887	5
Havering	40	262,022	6,551	7
Newham	44	350,626	7,969	2
Redbridge	43	309,836	7,205	3
Tower Hamlets	31	312,273	10,073	1
Waltham Forest	39	278,050	7,129	4
North East London	**269**	**1,999,915**	**7,435**	

Tower Hamlets has the highest average population per GP Practice across North East London

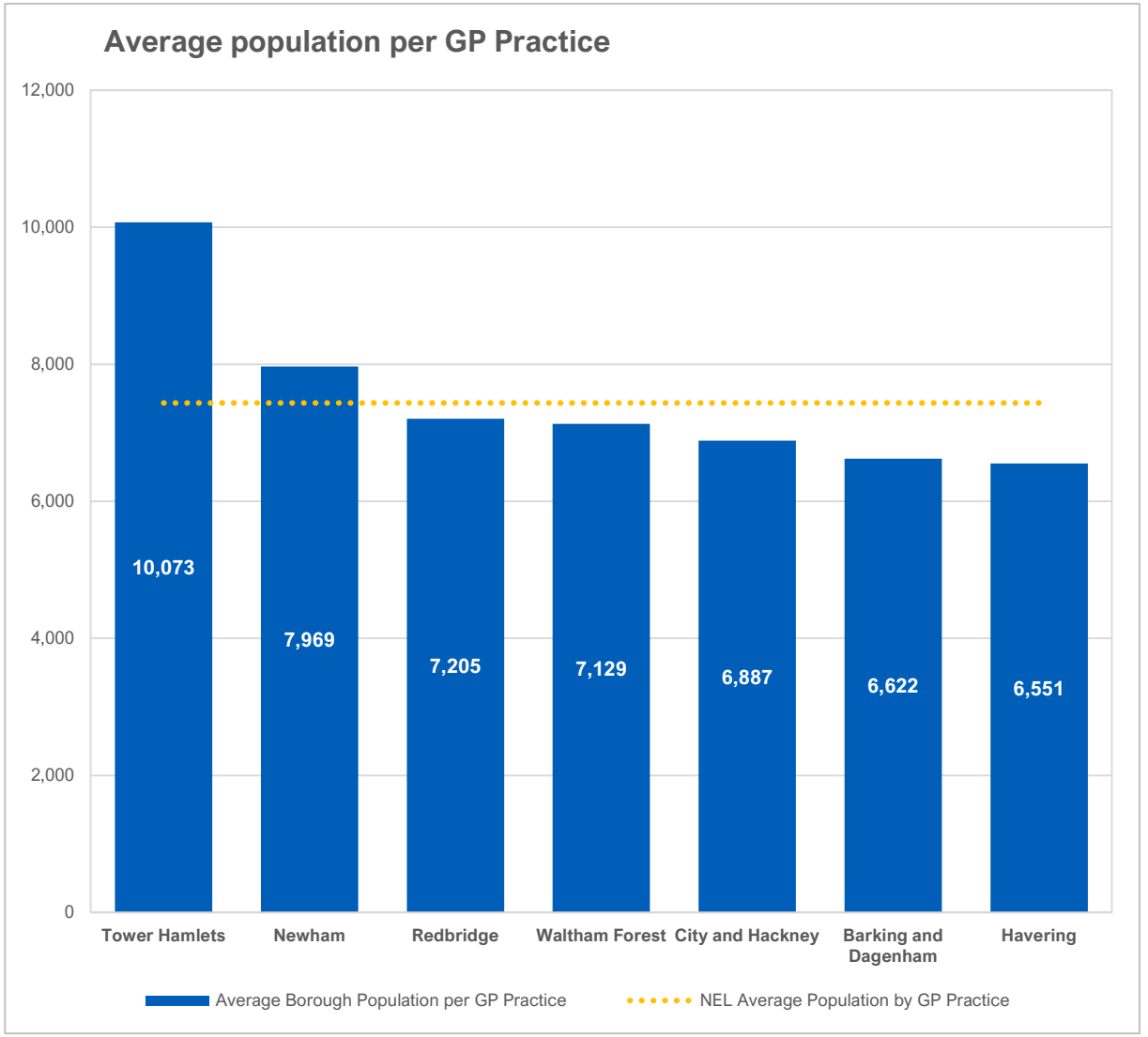
10,073 per GP Practice

Havering has the lowest average population per GP Practice across North East London

6,651 per GP Practice

North East London average population per GP Practice

7,435 per GP Practice



Data Source: Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

North East London Average population per GP WTE

Borough	Number of GP WTE	ONS 2021 MYE Population	Average Population per GP WTE	Rank Across NEL
Barking and Dagenham	120.48	218,534	1,814	4
City and Hackney	211.34	268,574	1,271	1
Havering	126.36	262,022	2,074	7
Newham	184.69	350,626	1,898	5
Redbridge	154.89	309,836	2,000	6
Tower Hamlets	194.84	312,273	1,603	2
Waltham Forest	154.87	278,050	1,795	3
North East London	**1147.46**	**1,999,915**	**1,743**	

Havering has the highest average population per GP WTE across North East London

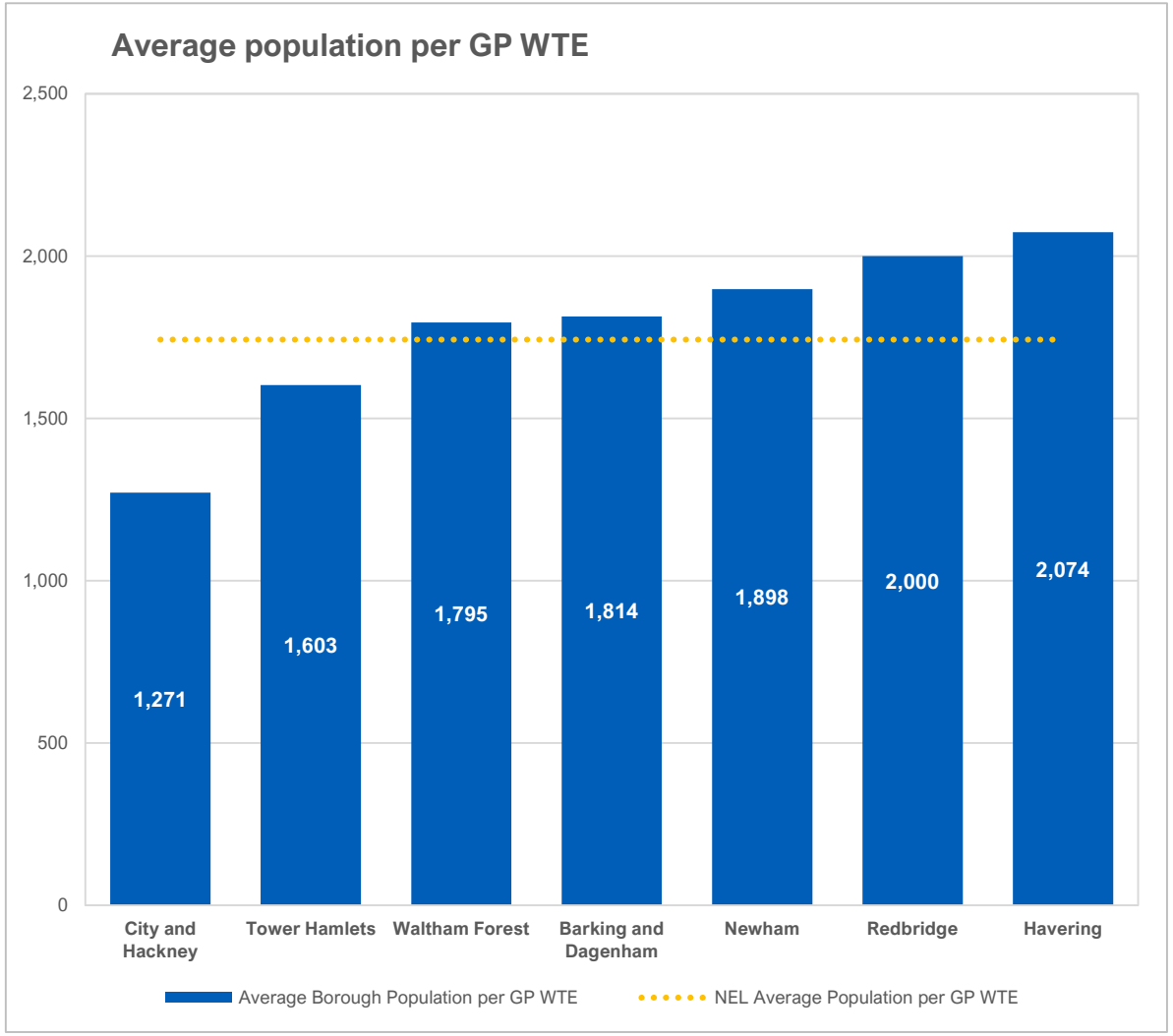
2,074 per GP WTE

City and Hackney has the lowest average population per GP WTE across North East London

1,271 per GP WTE

North East London average population per GP WTE

1,743 per GP WTE



Data Source: Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

North East London Average 65+ population per GP WTE

Borough	Number of GP WTE	65+ ONS 2021 MYE Population	Average Population 65+ per GP WTE	Rank Across NEL
Barking and Dagenham	120.48	19,123	159	4
City and Hackney	211.34	21,958	104	2
Havering	126.36	46,192	366	7
Newham	184.69	25,468	138	3
Redbridge	154.89	38,146	246	6
Tower Hamlets	194.84	17,606	90	1
Waltham Forest	154.87	28,584	185	5
North East London	**1147.46**	**197,077**	**172**	

Havering has the highest average 65+population per GP WTE across North East London

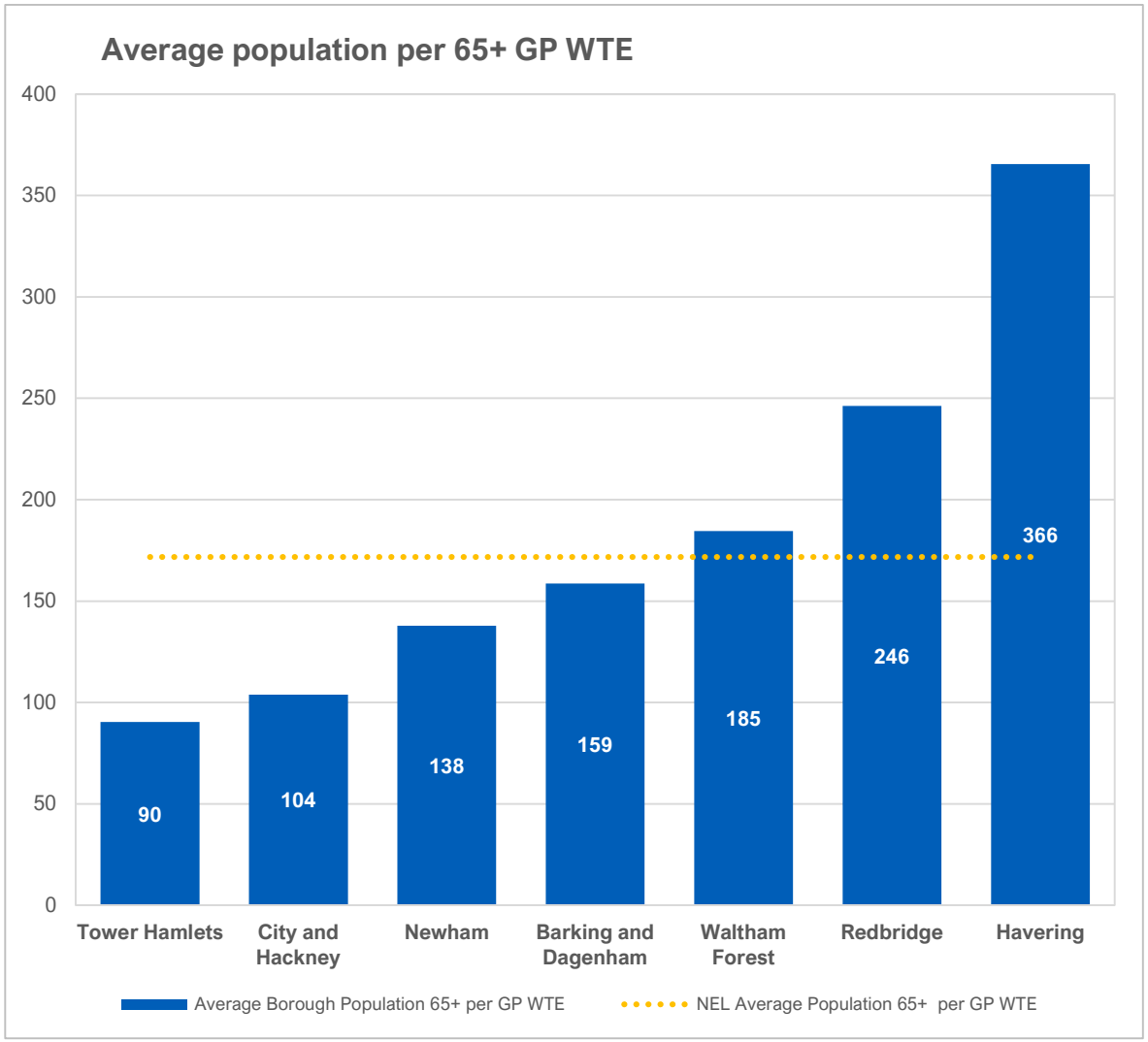
366 per GP WTE

Tower Hamlets has the lowest average 65+ population per GP WTE across North East London

90 per GP WTE

North East London average 65+ population per GP WTE

172 per GP WTE



Data Source: Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

North East London boroughs unemployment rates comparisons – March 2022

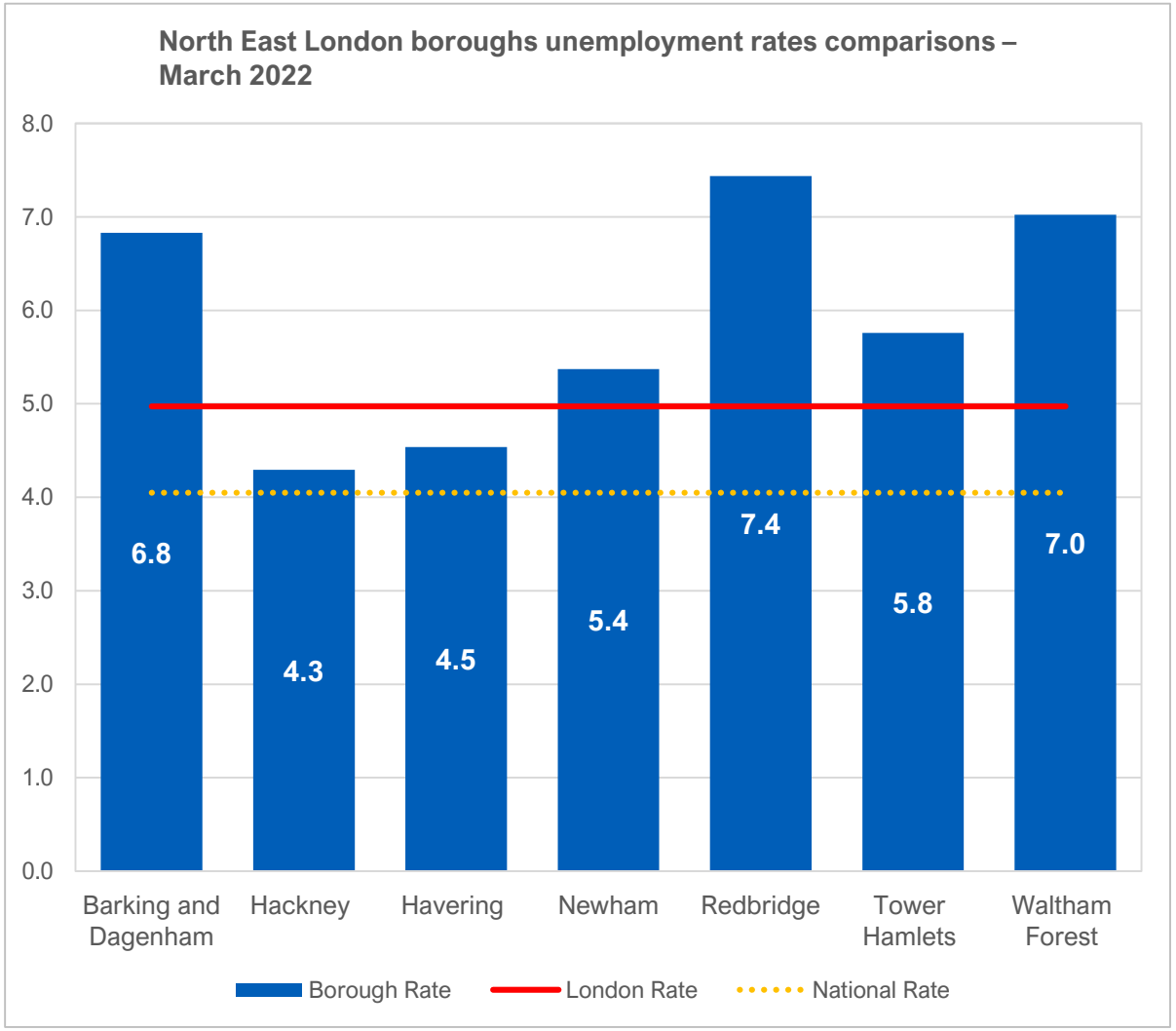
	Borough Rate	Rank across NEL	Higher Lower Rate than London	Higher Lower Rate than England
Barking and Dagenham	6.8	3	▲	▲
Hackney	4.3	7	▼	▲
Havering	4.5	6	▼	▲
Newham	5.4	5	▲	▲
Redbridge	7.4	1	▲	▲
Tower Hamlets	5.8	4	▲	▲
Waltham Forest	7.0	2	▲	▲
London	5.0			
England	4.1			

Redbridge has the highest unemployment rate of 7.4 across north East London

Hackney has the lowest unemployment rate of 4.3 across North East London

Two boroughs in North East London (Hackney and Havering) have a lower unemployment rate London (5.0). All other boroughs have a higher rate

All boroughs in North East London have a higher unemployment rate of England (4.1)



Data Source: [M01 Regional labour market: Modelled unemployment for local and unitary authorities - Office for National Statistics (ons.gov.uk)]

North East London population differences

Borough	ONS 2021 MYE Population	Ethnicity Breakdown 2021 Census	Variance	% Variance
Barking and Dagenham	218,534	217,180	-1,354	-0.62%
City and Hackney	268,574	257,740	-10,834	-4.03%
Havering	262,022	260,145	-1,877	-0.72%
Newham	350,626	349,740	-886	-0.25%
Redbridge	309,836	308,890	-946	-0.31%
Tower Hamlets	312,273	308,815	-3,458	-1.11%
Waltham Forest	278,050	277,160	-890	-0.32%
North East London	**1,999,915**	**1,979,670**	**-20,245**	**-1.01%**

Note: in the ONS 2021 Mid Year Estimate numbers population of City of London is identified separately in the 2021 Census Ethnicity breakdown City of London breakdown is included in City of London and Westminster.

City and Hackney has the largest difference between 2021 Mid Year Estimates and 2021 actual census ethnicity breakdown

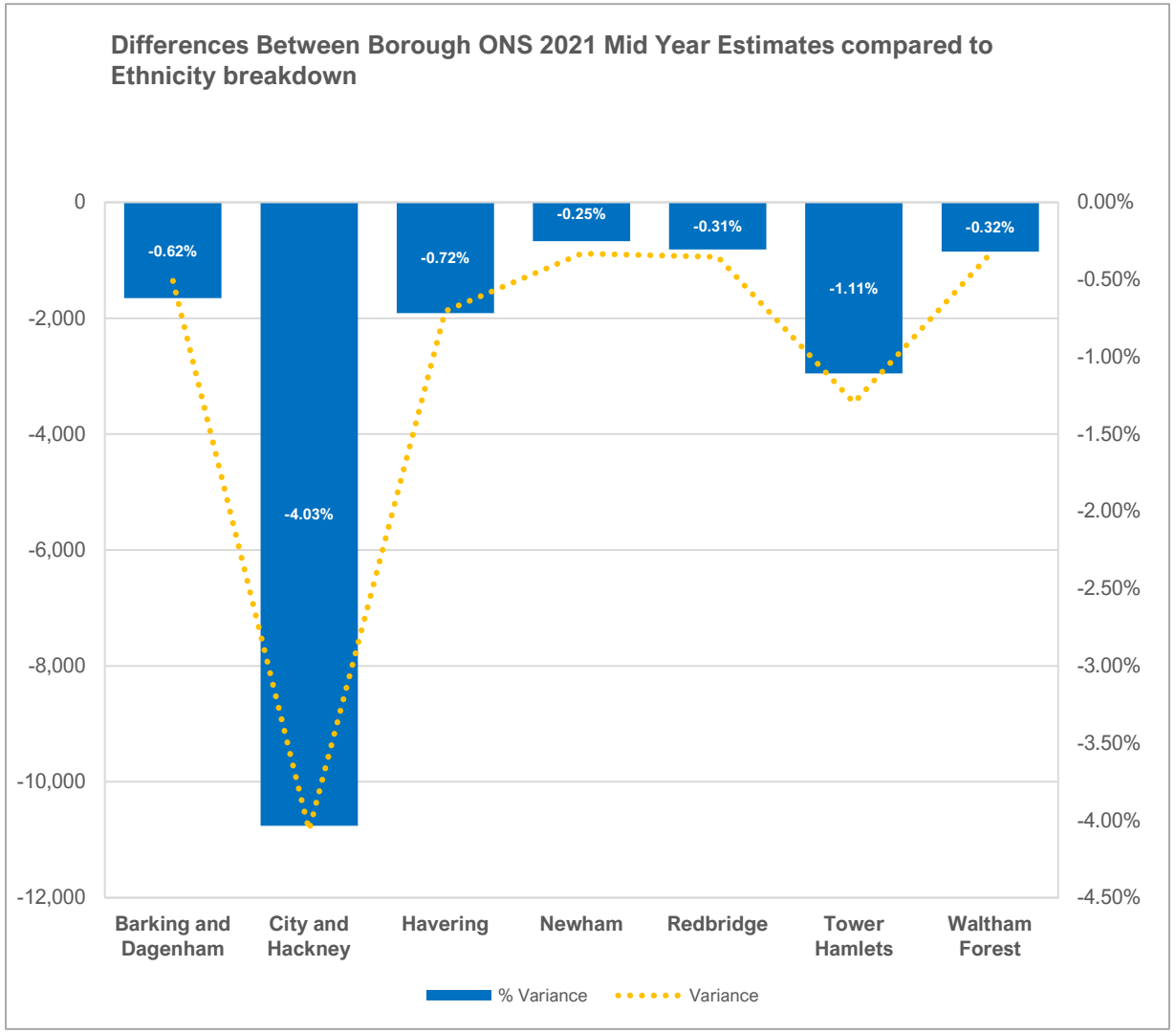
-10,834 (-4.03%)

Newham has the smallest difference between 2021 Mid Year Estimates and 2021 actual census ethnicity breakdown

-886 (-0.25%)

North East London difference between 2021 Mid Year Estimates and 2021 actual census ethnicity breakdown

-20,245 (-1.01%)



Data Source: Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk) ; Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Appendix- Definition and Data Sources – Population slides

1) **Total Population, Female and Male Population:** taken from 2021 ONS Mid year estimate population by Local Authority area.
2) **% Male and Female Population:** Calculated by dividing male/female population by total population.
3) **16-64 Population, Female and Male Population:** taken from 2021 ONS Mid year estimate population by Local Authority area, calculated by summing single age breakdowns.
4) **%16-64 Total Male and Female Population:** Calculated by dividing total/male/female 16-64 population by all ages total/male/female population.

Data Source: Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

Appendix- Definition and Data Sources – Diversity slides

1) **Ethnic group age band breakdown:** taken from 2021 census by Local Authority area. Single year age breakdown by ethnic group
2) **% by Ethnic group :** Calculated by dividing population by group by total population.
3) **% by Ethnic minorities :** Calculated by summing all categories apart from white and dividing by total population.

Data Source: Ethnic group by age and sex in England and Wales - Office for National Statistics (ons.gov.uk)

Appendix- Definitions and Data Sources Workforce – GP data, Residential Care Homes slides

1) **Headcount of GPs, Nurses, Other Healthcare Professionals and Admin-Clinical Support :** For Tower Hamlets the numbers are taken from The Edenbridge system for all other boroughs data an the Consolidated North East London the data is taken from the monthly NHS Digital Monthly GP workforce return this data is consolidated from the workforce Minimum Data Set (wMDS) for Primary Care.

2) **Headcount of Other:** For Tower Hamlets the numbers are taken from The Edenbridge system this is a category for staff that are not classified.

3) **Number of Residential Care Homes :** Count of the number of residential care homes in each borough, taken from NECS Capacity tracker system.

4) **Number of Nurses :** Number of Nurses working in residential care homes this can be split by substantive and agency staff taken from NECS Capacity tracker system.

5) **Number of Care workers :** Number of Care workers working in residential care homes this can be split by substantive and agency staff taken from NECS Capacity tracker system.

6) **Number of Nurses :** Number of Nurses working in residential care homes this can be split by substantive and agency staff taken from NECS Capacity tracker system.

Data Source: GP Data General Practice Workforce - NHS Digital Residential and Nursing Homes Home - Capacity Tracker

Appendix- Definitions and Data Source - Unemployment Slides

1) **Unemployed Numbers** - These figures are based on a model which utilises Annual Population Survey estimates of unemployment along with the Claimant Count averaged over 12 months.

2) **Unemployment Rate** - Calculation of headline unemployment rate: number of unemployed people aged 16 years and over, divided by the sum of employed people aged 16 years and over, plus unemployed people aged 16 years and over.

Data Source: M01 Regional labour market: Modelled unemployment for local and unitary authorities - Office for National Statistics (ons.gov.uk)

Appendix- Definitions and Data Source - Average population per GP Practice

1) **Total Population, Female and Male Population:** taken from 2021 ONS Mid year estimate population by Local Authority area.

2) **Number of General Practices** – taken from latest GP Practice to PCN download published by NHS Digital data as at 24th February 2023.

3) **Average population per GP Practices**– taken from dividing the 2021 ONS Mid year estimate population by the no of GP Practices contained within the latest GP Practice to PCN download released by NHS Digital.

Data Source Population: Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

Data Source GP Practices to PCNs: https://nhs-prod.global.ssl.fastly.net/binaries/content/assets/website-assets/services/ods/data-downloads-other-nhs-organisations/epcn.zip

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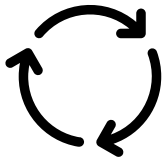
Our Strategic Context

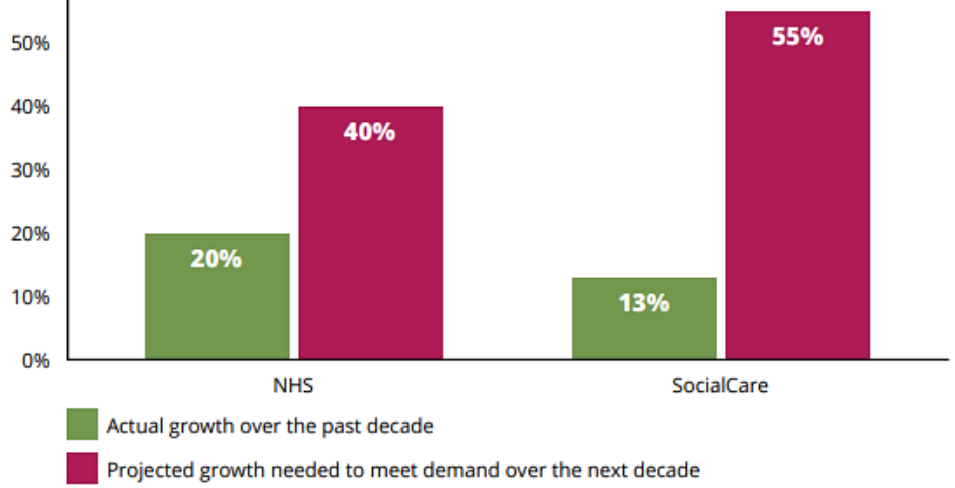
We have **94,200 paid staff** working in health and care services in NEL.
This number does not including staff employed by the voluntary sector and carers

- 46,000 in Social Care
- 44,100 in NEL Providers (not including bank and agency)
- 4,100 in General Practice



Turnover rates

- Social Care – 23.3%
- NHS Trusts – 11.4%



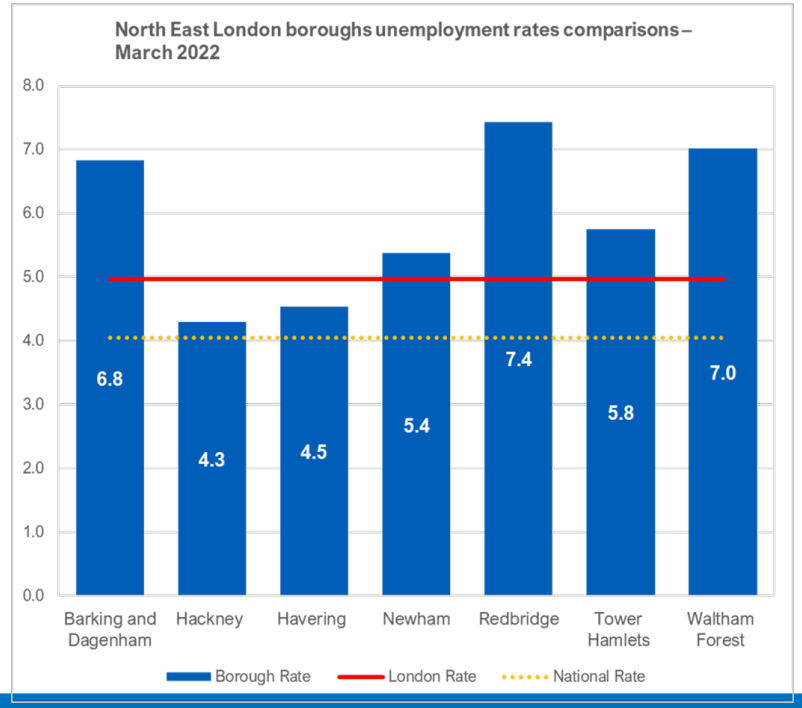
- Sickness rates
- Social Care - 3.15%
- NHS Trusts in NEL have an average rate of 4.9% compared to a national target of 4%

*Data used is from different sources but accessed through Health Education England's e-product where in addition we can compare these data sets across regions and integrated care systems.
**Source: REAL Centre calculations based on data from NHS Digital and Skills for Care.
Note: For the NHS, previous decade is June 2011–June 2021 and next decade is 2018/19 to 2030/31. For social care, previous decade is 2012/13 to 2020/21 and next decade is 2018/19 to 2030/31. Growth rates for the NHS and social care are calculated on a full-time equivalent basis.

Our Workforce Opportunities – Unemployment by Borough

- The top three NEL boroughs with the highest unemployment rates are:
  - Redbridge (7.4%)
  - Waltham Forest (7.0%)
  - Barking and Dagenham (6.8%)

- Hackney has the lowest unemployment rate of 4.3%
- Unemployment rates in all NEL boroughs are above the England average of 4.1%
- Two boroughs, Hackney and Havering have lower rates than the London average rate of 5.0%



Borough	Unemployment Rate	Number of Unemployed People
Barking and Dagenham	6.8%	7,200
Hackney	4.3%	7,900
Havering	4.3%	6,700
Newham	5.4%	10, 900
Redbridge	7.4%	11,600
Tower Hamlets	5.8%	10,800
Waltham Forest	7.0%	10,800

Ethnic Diversity per Borough - Headlines

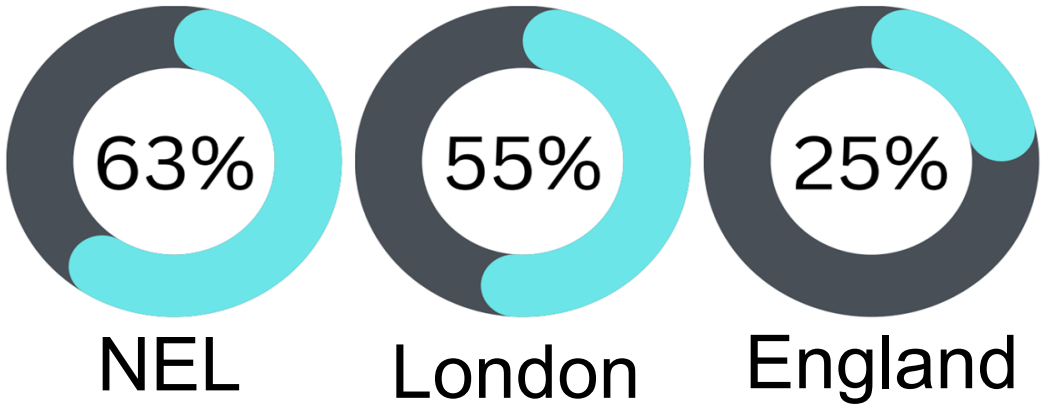
There are key differences in the ethnic diversity across our boroughs, for example:

- **Newham** – less than a quarter of the 16-24 population is white (23%.9%)
- **Havering** – almost three quarters (72.5%) of the 16-24 population is white
- **Barking** – over half of the 16-24 population is BAME with an equal percentage of Black and Asian minorities (both 25.6%)
- **Redbridge** – over half the 16-24 population is Asian (51.8%)

The evidence underpins the need for the development and implementation of culturally-sensitive workforce strategies, solutions and interventions as we seek to offer employment to underrepresented groups in our local populationsF

Our Future Workforce – Key Takeaways

- We are the most diverse ICS in the country with over half (53%) of NEL's population identifying as Black, Asian or from an ethnic minority compared with 11% across England overall.
- North East London has a significantly diverse and young population
- 63% of our 16-24 year olds identify as Black, Asian or from Ethnic Minority
- Black, Asian or from Ethnic minorities % for NEL 16-24 compared to London and England

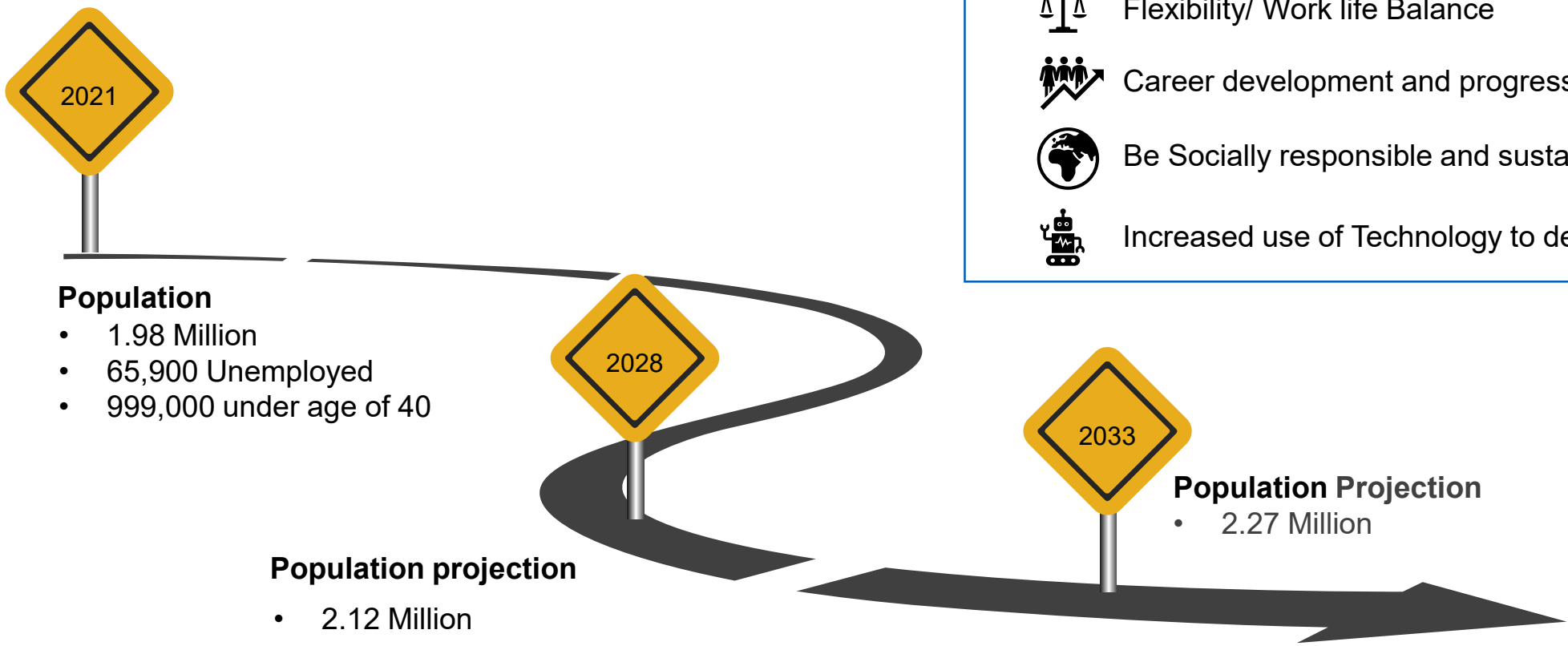


For full details see Appendix C

Horizon Scanning – Population and Workforce

To attract the workforce of the future, we will need to offer

- Flexibility/ Work life Balance
- Career development and progression
- Be Socially responsible and sustainable
- Increased use of Technology to deliver work



Population

- 1.98 Million
- 65,900 Unemployed
- 999,000 under age of 40

Population projection

- 2.12 Million

Population Projection

- 2.27 Million

Work with planning and insights team to establish workforce requirements for the next 20 years bringing, population, activity and workforce data together

North East London Health & Care Partnership

North East London(NEL) People and Workforce Strategy Development

Table of Contents

Our Four System Priorities

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

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

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

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

For full details see Appendix A

Timeline of Development

November Workshop

Key themes from the initial engagement were used to develop further engagement sessions with all stakeholders

January - April

Bespoke engagement sessions with our partners across the system

Whole system workshop – Monday 24th April

See details of stakeholders in Appendix E

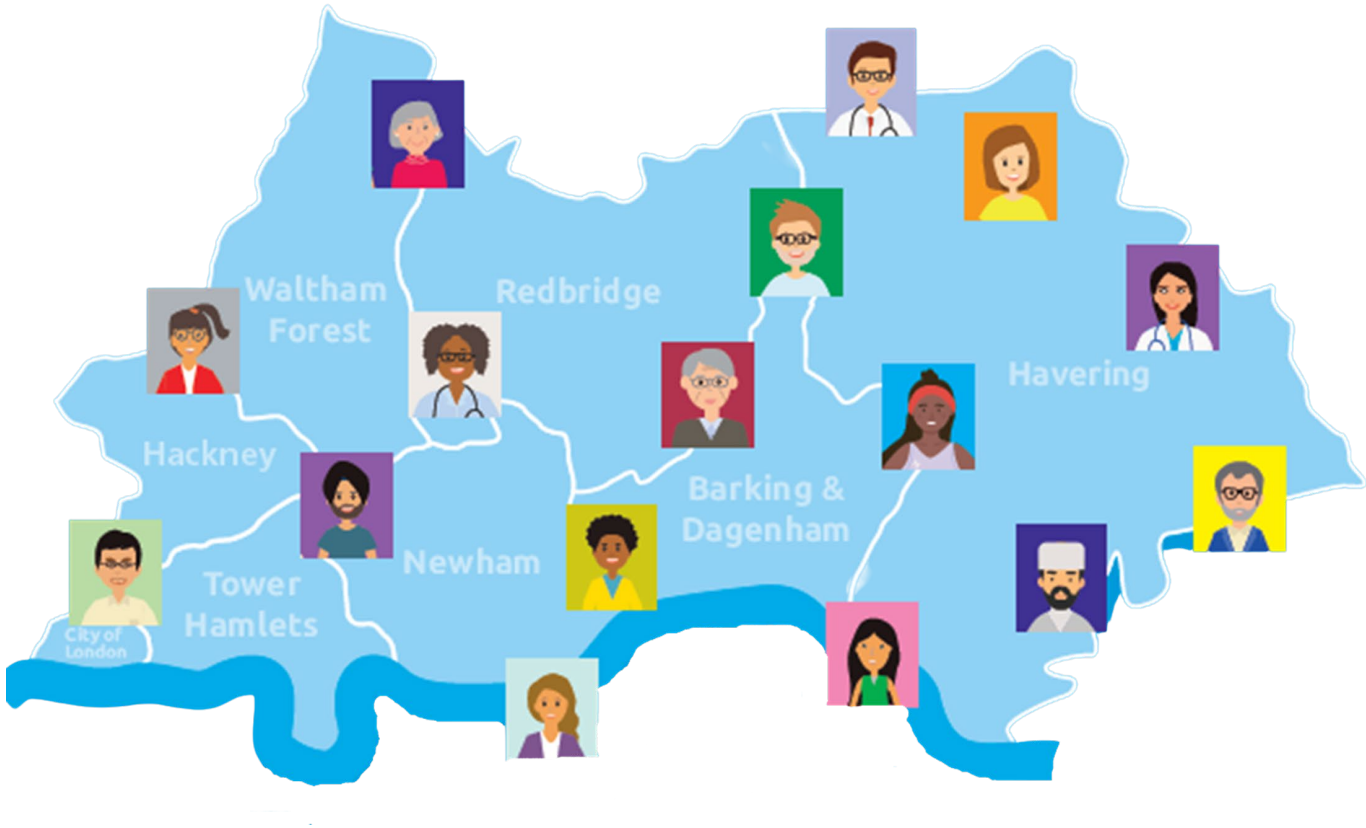
May - July

We will collaborate with system partners to develop a detailed five-year strategy delivery action plan

Delivery of five year plan across the system

Our Places

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



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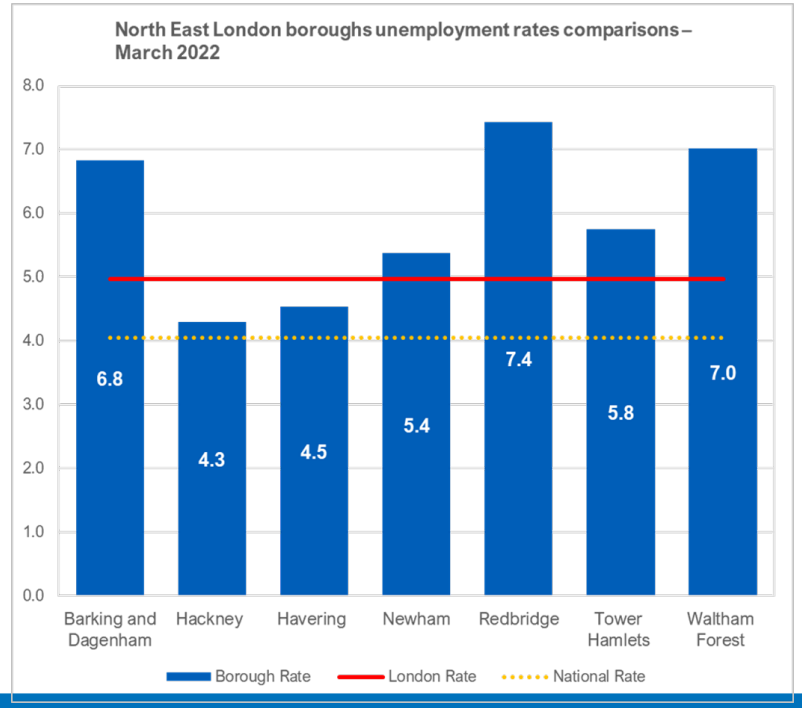


Borough	Unemployment Rate	Number of Unemployed People
Barking and Dagenham	6.8%	7,200
Hackney	4.3%	7,900
Havering	4.3%	6,700
Newham	5.4%	10, 900
Redbridge	7.4%	11,600
Tower Hamlets	5.8%	10,800
Waltham Forest	7.0%	10,800

For full details see Appendix B

Our Potential Workforce – Key Takeaways

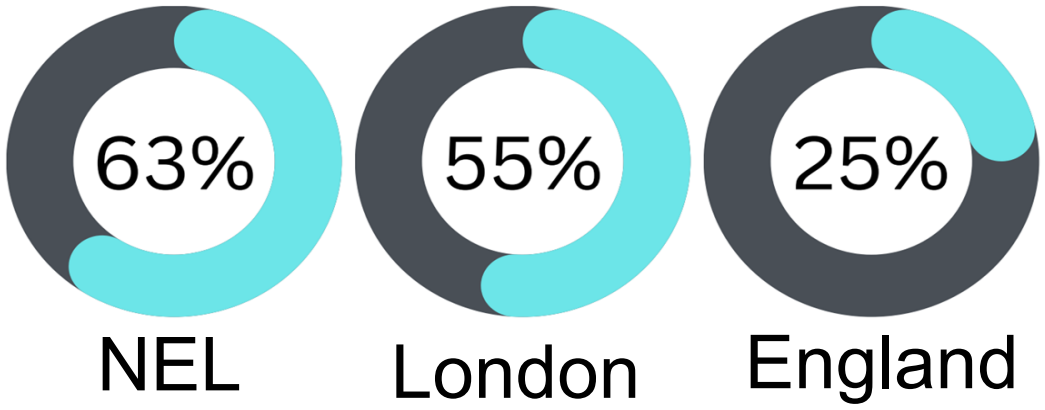
- NEL borough unemployment rates present a huge opportunity and supply potential for attracting and bringing unemployed people from our local populations into a system-wide health and care workforce.
- There is significant diversity in the ethnic mix, profile and composition of NEL unemployed populations that varies in complexity from borough to borough and includes under-representative groups

<u>Mitigations</u>

- Health and Care careers need to be innovative, flexible and redesigned to include new roles that support new ways of working and offer more employment opportunities for our local populations
- Key enablers at System, Place, Neighbourhood and in our Collaboratives to ensure delivery of these strategic objectives, need to be identified and agreed in collaboration with key stakeholders through this strategy development and five year action planning process
- System workforce recruitment, retention and health and well-being strategies need to be innovative, targeted, locally-tailored, inclusive and culturally-specific. → **There are no 'one size fits all' workforce solutions**.
- Our system people and workforce strategies need to be sufficiently innovative, adaptable and flexible so as to leverage the collective strengths implicit in the rich diversity of our local NEL populations, towards developing a joined up, 'One Workforce' for health and care employers.

Our Future Workforce – Key Takeaways

- We are the most diverse ICS in the country with over half (53%) of NEL's population identifying as Black, Asian or from an ethnic minority compared with 11% across England overall.
- North East London has a significantly diverse and young population
- 63% of our 16-24 year olds identify as Black, Asian or from Ethnic Minority
- Black, Asian or from Ethnic minorities % for NEL 16-24 compared to London and England



For full details see Appendix C

Ethnic Diversity per Borough - Headlines

There are key differences in the ethnic diversity across our boroughs, for example:

- **Newham** – less than a quarter of the 16-24 population is white (23%.9%)
- **Havering** – almost three quarters (72.5%) of the 16-24 population is white
- **Barking** – over half of the 16-24 population is BAME with an equal percentage of Black and Asian minorities (both 25.6%)
- **Redbridge** – over half the 16-24 population is Asian (51.8%)

The evidence underpins the need for the development and implementation of culturally-sensitive workforce strategies, solutions and interventions as we seek to offer employment to underrepresented groups in our local populations

For full details see Appendix C

Our System Partners

Our Engagement Approach

Hold co-design workshops and engagement sessions to develop an innovative, collaborative, responsive and flexible employment model with critical workforce and people enablers and pillars to support emerging system care strategies and priorities.

Hold communication and engagement pre-meets with key stakeholders where there has been no prior engagement to manage expectations, understand their preferred mode of engagement and create buy-in.

Previous Development from NHS CPOs

Delivering the NEL people Plan – model of working

Data

Data driven and evidence based people related decision making

Engagement

Engagement of relevant stakeholders

Ownership

Ownership of priority areas by identified SROs

Celebration

Celebration of incremental progress

Delivery of our NEL people plan will be underpinned by the above principles

For full details see Appendix F

Alignment of 2020-21 People Plan, London and NEL Priorities

There is broad level of alignment across the plans

Exceptions to alignment include:

- Within the London 6 priorities, Primary care and utilising digital solutions is not included
- Belonging in the NHS is not included in the plan nor with our local focus on equality and diversity in our workforce
- Observing and understanding the work stream development of the London priorities will ensure alignment and avoid duplication

2020-21 People Plan – Priorities Sept 2020

- Looking after our people
- Belonging in the NHS
- Growing our Workforce
- New Ways of working

London People Board Priorities July 2020

- Caring for and celebrating our people
- Training and development for critical care
- Enhanced Medical Education
- Attracting People into the NHS
- Sustaining and growing nursing
- Ensuring Productive Working across London

NEL Priorities

Where priorities are broadly aligned these are reflected in the colour coding

What we reviewed in November 2022

We have a high level of vacant posts, resulting in an increased reliance on temporary staffing and increasing costs and turnover rising following the pandemic

We have an ageing workforce - meaning that a large percentage of highly skilled and experienced staff are due to retire in the coming years – Primary and Social Care have some specific challenges with General Practice Nurses and care workers

High levels of sickness absence, with musculoskeletal injuries and stress/anxiety being two of the top reasons for absence

Significant disparity in pay between sectors and employment models (more permanent posts in Health, In Social Care a high proportion of Zero hours)

Wage increases in other sectors, retail and service industries

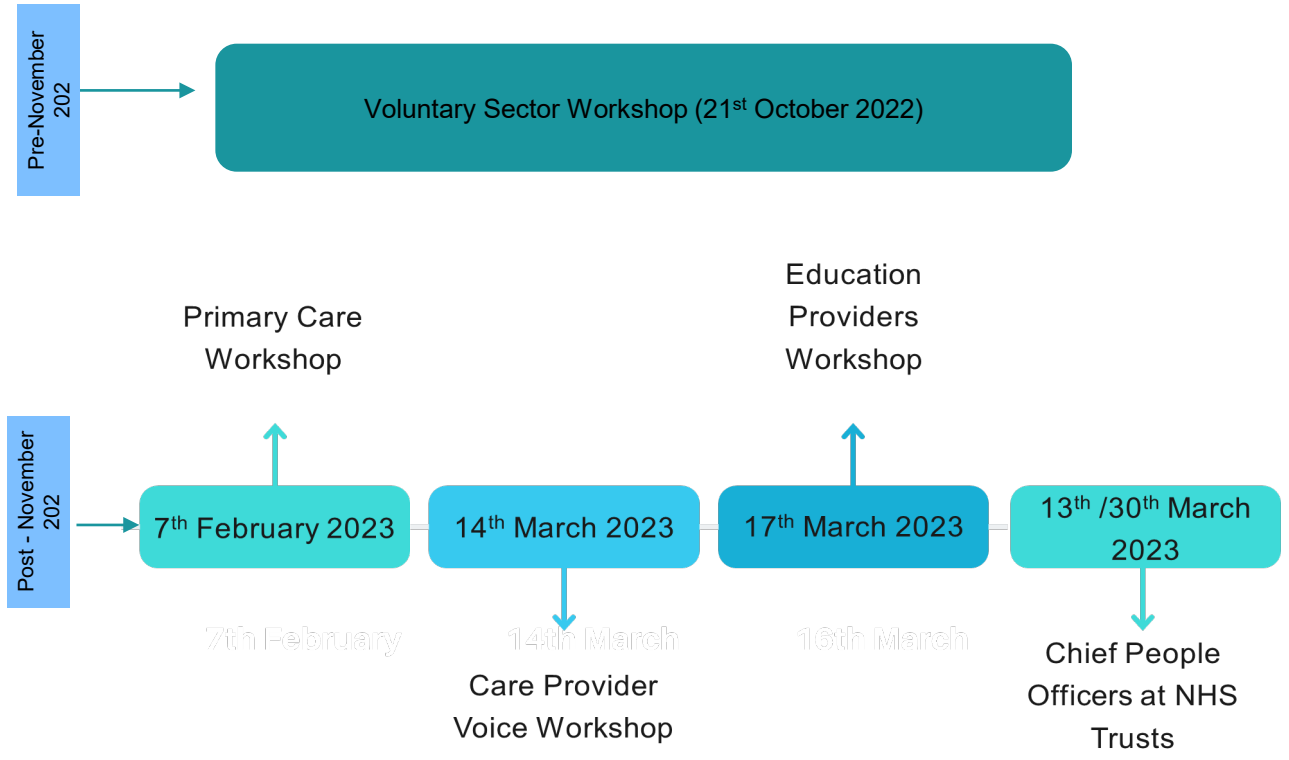
The current demand on services means that a flexible employment offer is limited in some areas

Key themes and actions from the Workforce Strategy Workshop on 1st November 2022

- **Stakeholders from all parts of our ICS attended a workshop on 1st November- delegates represented a wide range of sectors and providers including health, care, local authority and the voluntary sector.**
- **Delegates came together and shared their motivation to improve the need to address the disparity within our workforce in NEL.**
- **There was broad agreement on considerations and work to address the challenges across key priorities extracted from the input of the group discussions.**

Theme	Actions
Transformation / Innovation	• Looking at future and current challenges through an innovative lens to create meaningful work opportunities. • Embed transformative/innovative ways of working to address the themes and outputs in the strategy (thinking outside the box). • Redesign roles to address the workforce supply challenges.
Recruitment	• Making our recruitment processes lean and accessible • Creating effective partnerships with our communities to access work opportunities in health and care
Retention	• Develop our workforce and seek to retain them not only within our organisations but across NEL • Build processes to support inter organisation transfers
Health and Well being	• A consistent offer to support staff to recover from the pandemic • Support for staff to manage through the cost of living approaches • Build a targeted health and well-being offer at NEL level for all staff building on our Keeping Well NEL Platform
Addressing Inequity	• Access to training across NEL • Work across employers to develop solutions to ensure progress and a plan that at our workforce is demographically representative and reflect the community it serves • Identifying the groups in the communities in our demographic which are under-represented in the workplace, including ethnic communities, neurodivergent people and those with mental health conditions.
Grow our Talent	• Create a consistent pipeline and offer that educates, training and employs staff in NEL, utilising system wide approaches for all sectors • Utilise and promote opportunities for local residents to work and build careers in our organisations • Redesign work and skill requirements that match the demand of the future population.
Developing a NEL employment deal	• A consistent offer of development, flexibility and mobility across organisations that all in NEL sign up to, including recognition of skills across sectors and professions

Engagements/ Workshops



We have engaged with about 40 people individually and jointly, (See Appendix E) including:

- Local Authorities/Place Leaders – On-going engagement.
  - Initial engagement meetings held with Havering, Newham and Redbridge Chief Executive Officers.
- Collaboratives – Acute, Mental Health, Community – On-going engagement
- Anchor Organisations Programme Lead – On-going engagement on programme progress and updates
- Voluntary Sector Stakeholders - On-going engagement

For full details see Appendix E

Workshop Engagement Sessions (2023)

- Across all partners we aimed to gather information on:
  - What is working well?
  - What are the challenges, gaps and problems we need solved?
  - What does good look like in the next five years based on population demand?
  - What are the key enablers?

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For full details see Appendix D

What's working well?

Primary Care	Care Providers	Local Government	Provider Collaboratives	Voluntary Sector	Education Providers	NHS Trusts
• Workforce Transformation Group • Hackney model ◦ Health and care interface with providers and social care • General Practice Fellowship SPIN scheme	• Willingness to collaborate • Sharing experience and solutions across local authorities and providers	• Collaboration with education providers on initiatives to get under-represented population groups into employment • Collaboration on apprenticeships • All boroughs have some form of Social Care Academy • Good initiatives around diverse cultural sensitivity and targeted support around employment opportunities and impact	• The role of the Non-Clinical Navigator (NCN) had already been successfully piloted at the Homerton Hospital • Physician associates, advanced clinical practitioners and emergency practitioners	• Innovative roles and flexibility • Entry into wider health and care system	• Joint commissioning of apprenticeship delivery • Recognition of the expanding population as a strength for the future • BHR Academy data dashboard supporting workforce planning • Innovation underpinned by senior leaders	• NEL People Plan has already been developed • Sharing of best practice through the Chief People Officer Network • The successful delivery of 4 million vaccinations showing the benefits of collaborative system working

System Working Example - Apprenticeships

- The NEL Health and Care Partnership/Building Access and Careers Apprenticeship project supports the NEL system to stimulate increased take up of 'fit for purpose' apprenticeships that support **workforce transformation** as well as **career progression** and **recruitment.**
- Building on the good work that already happening across the system – creating opportunities for joint working
- Creating tailored apprenticeships that meet our NEL workforce needs – added value for no added cost – joint working means greater 'buying power'
- Piloting creative use of apprenticeships to meet workforce challenges – and supporting scale up across NEL
- Supporting excellence – sharing good practice, supporting review and Quality assurance activities

For further details see Appendix G

Some NEL Apprenticeship activities

North East London Health & Care Partnership

System Working Example – Acute Provider Collaboratives New Roles Initiative

- Physician Associate
  - Main duties:
    - Work alongside doctors to provide medical care
    - Take medical histories, carry out physical exams, formulate diagnoses and management plans, perform diagnostic and therapeutic procedures

- Advanced Clinical Practitioner
  - Main duties:
    - Asses, investigate, diagnose, plan, implement, and evaluate, the clinical care of patients.
    - Can (if agreed by the hospital) be a non-medical prescriber for medication and ionizing radiation.

- Emergency Practitioner
  - Main duties:
    - Management of minor injuries and illnesses

Current Locations of PAs and ACPs

Trust	Hospital	PAs	ACPs
Homerton University NHS Trust	Homerton Hospital	1	2
Barking, Havering & Redbridge University Trust	Queen's Hospital	16	4
	King George Hospital	0	0
Barts Health NHS Trust	The Royal London Hospital	7	7
	Whipps Cross Hospital	0	4
	Newham Hospital	0	8
Totals		**25**	**24**

(Note; currently, all PAs and ACPs are employed and utilised in Adult EDs.)

System Working Example – Acute Provider Collaboratives Non Clinical Navigator (NCN)

- NCNs were key to increasing GP registration. At least 38% of patients shown how to register with a GP, actually registered, and 70% of these patients registered with the GP suggested by the NCN

- The NCNs provided holistic patient support by signposting to other services including dentists, sexual health providers, mental health providers, pharmacy, podiatry, opticians, osteopathy and travel clinic

- Patients were able to be seen in the most suitable place for their care in a timely way

- Patient satisfaction (monitored through the Friends and Family survey) increased

Barriers to meeting population demand

Primary Care	Care Providers	Local Government	Provider Collaboratives	Voluntary Sector	Education Providers	NHS Trusts

• Changing model of GP Practices from ownership/partner GPs to Employee/Locum GPs
  ◦ Retention and Succession Planning implications
• Legal frameworks which limit the ability to create change
• Lack of a link between primary care and borough partnerships
• Difficult to survey staff wellbeing as practices run differently
	• Providers not being part of all the relevant conversations with health and place
	• There is a lack of pay parity across providers
	• Perception of care in the media is damaging recruitment into to the sector
		• Critical workforce shortages in a significant number of roles
		• Challenges with recruitment
		• High turnover, low retention
		• Poor perception of health and care
		• Lack of affordable housing for local staff
			• Loss of employees to independent sector
			• Issues around recruitment & retention
			  ◦ Attracting and retaining Gen Z applicants
			• NHS Jobs / TRAC processes are difficult to navigate
			• High costs of temporary staff
			• Differential inner/outer weightings
			• 'Selling' apprenticeships to services
			• No time for training or strategic planning
				• Accessing training opportunities for staff across the wider system
				• Terms and conditions equity with other parts of the sector
				• Retention
					• Lack of diversity in decision making
					• Trying to do too many things rather than focusing on a few key priorities
					• Younger generations not understanding the career options and not recognising the impact of parents in career decision making
						• Lack of recovery time for staff since the pandemic and future peaks in demand
						• Lack of staff engagement in workforce plans
						• Industrial action adds extra pressures to staff

What does good look like?

Primary Care	Care Providers	Local Government	Provider Collaboratives	Voluntary Sector	Education Providers	NHS Trusts
• Centrally organised training programmes facilitated by training hubs • Clear idea of what we mean by "collaboration" • Breaking down the contractual ways of working • Shared vision around the health of our population	• Care providers holding roles across the ICB to have a fully integrated system • Better understanding of social care as a sector • ME Passport to support workers to move	• More joined up working between boroughs eg on recruitment • Collaboration around identified areas of duplication eg social care academies • Seamlessness and flexibility of workforce between boroughs • London living wage • Pay parity between	• Grow our own approach to entry level roles • Strategic approach to scaling up apprenticeships • Develop NEL Mental Health collaborative offer • Expansion of nurse placements • People participation and peer support workforce	• Involvement in workforce projects at early stages	• Strong pipeline of people coming through the system • Clear implementation plans with measures to assess progress • Full utilisation of system apprenticeship levy • Have access to system wide workforce data sets	• Health and wellbeing offer for all health and care staff in NEL • Talent framework to ensure staff can develop in their career in both health and care • Agreement to share our workforce across providers initially with a focus on acute transformati

Priorities from Workshops

Primary Care

Education Providers

Care Providers

Key enablers

Primary Care	Care Providers	Local Government	Provider Collaboratives	Voluntary Sector	Education Providers	NHS Trusts
• Changing ways of working into collaborative methods • Gap analysis • Reduction of duplication	• Access to NHS training • NEL wide funding for Care Provider Voice (CPV) to represent the views of providers at a system level • One recruitment offer	• Affordable housing for employees	• Grow our own approach to entry level roles • Strategic approach to scaling up apprenticeships • Develop NEL MH collaborative offer • Expansion of nurse placements • People participation and peer support workforce	• Development of voluntary sector collaborative	• Apprenticeships need to be prioritised • Innovative approaches to career pathways • Recognise parents as a key stakeholder in influencing young peoples career choices	• Shared workforce planning tool • Maximise use of the apprentice levy and share across the system

Identified Themes

NEL Employment Offer	Grow Our Own	Training and Retention	Collaboration and Innovation	Health and Wellbeing	Recruitment
• A consistent offer of development, flexibility and mobility across organisations that all in NEL sign up to, including recognition of skills across sectors and professions. • Acknowledge the unique issues for each borough/sector. • Account for culturally specific sensitivities	• Create a consistent pipeline that educates, trains and employs staff in with a system wide approaches for all sectors • Redesign work and skill requirements that are flexible and match the demand of the future population and deliver	• Joint training sharing and giving equal access to training to all across sectors • Transfer opportunities across organisations and sector	• New clinical and service models leading to new roles • Meaningful and attractive roles for staff delivering services • System-wide workforce planning with innovative new roles and joint teams working in new ways	• A consistent offer to support all staff to recover from the pandemic • Support for staff to manage through the cost-of-living challenge • Build a targeted health and well-being offer at NEL level	• Accessible and lean processes – reduction in time to recruit • Target and promote offer for local communities • Change in employment application process and values-based recruitment adapted to the diversity of local populations

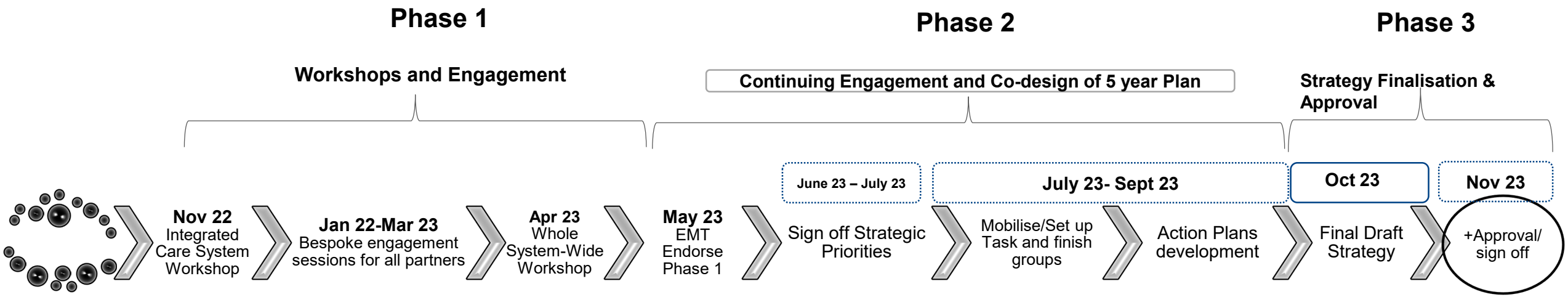
Emerging Key Strategic Success Factors

- The increasing ethnic diversity of our local populations as age brackets decrease means that our people and workforce strategies, solutions and interventions need to be increasingly culturally-sensitive and specific in orientation as we seek to employ locally under-represented population groups into our workforce.
- We need an innovative career development model that enables us to develop a united, joined up NEL workforce that works flexibly in new ways and can be seamlessly deployed across health and care and across borough boundaries.
- We need to focus on the ‘Attractiveness of Our Offer’ to encourage young people, older people and other under-represented groups in our communities to choose to work in health and care roles - including adopting values-based recruitment and the removal of entry barriers and bureaucratic application processes.
- We need to remove the stigma especially associated with working in care and seek to achieve parity in health and care employment terms and conditions and to develop a collaborative culture that enables and facilitates joint working. This should include a review of ‘health dominated language and abbreviations’.

Emerging Key Strategic Success Factors

- We need to recognise the changing model of primary care as it moves from a local GP to a Neighbourhood model and the implications that this has for developing and implementing people and workforce strategies and solutions and accountabilities which will ensure the continuous supply, development, health and well-being and inclusion and retention of a largely fragmented workforce - which currently has no national/regional benchmarked feedback mechanisms, like staff surveys.
- We need to identify areas of duplication of existing good practice across NEL where we can have joined-up collaborative solutions hosted at system, place or neighbourhood to promote productivity and economies of scale
- We need the right leadership working together and not in competition to support and enable a motivated, fit for purpose, ‘United NEL workforce’

Our Development Journey



Next Steps

May 2023
EMT Endorse Phase 1

June/July 2023
Sign Off Strategic Priorities

July 2023
Start Co-design and Engagement for Phase 2

July 2023
Mobilise and establish System Task and Finish groups

Aug/ Sept 2023
Collate System Action Plans

Oct 2023
Final Draft NEL People and Workforce Strategy

Nov 2023
Endorse/approval

Endorse/ Final Approve/Sign Off
+Executive Management Team (EM
+ICB Executive Committee
+People Board
+Integrated Care Partnership Board
+Workforce Remuneration Committe
+ICB Board

Governance

- Governance arrangements to be established at:
  - System
  - Place
  - Neighbourhood
  - Collaboratives

- Funding sources and other key enablers to ensure effective and sustainable implementation and delivery of strategy action plan priorities will need to be agreed at System, Place, Neighbourhood and in our Collaboratives.

NHS
North East London
Integrated Care Board

NHS North East London ICB Board

26 July 2023

Title of report	Deep Dive: Health Inequalities
Author	Hilary Ross, Director of Strategy Ellen Bloomer, Consultant in Public Health
Presented by	Paul Gilluley, Chief Medical Officer Hilary Ross, Director of Strategy
Contact for further information	Ellen Bloomer, Consultant in Public Health, ellen.bloomer@nhs.net
Executive summary	This report provides context to the work on health inequalities in North East London (NEL), sets out the roles of, and opportunities for, different parts of the system and highlights some of the progress that has been made as a system so far. Sustained action from all partners within the Integrated Care System (ICS) is critical to making a tangible difference for our population. This is intended as a background paper to support a 'deep dive' discussion at the ICB board. Some questions for discussion are included at the end of the paper.
Action / recommendation	Note
Previous reporting	Progress with our work on health inequalities is reported to a Steering Group co-chaired by Paul Gilluley and Jason Strelitz, Director of Public Health at London Borough of Newham and also to the ICB Population Health and Integration Committee.
Next steps/ onward reporting	N/A
Conflicts of interest	None
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To support broader social and economic development
Impact on local people, health inequalities and sustainability	This report is intended to support discussion by the ICB Board as to how we can accelerate action to reduce health inequalities and improve health outcomes for local people equitably across NEL.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capital costs arising from this report. This report is intended to support discussion by the ICB Board.
Risks	N/A

1.0 Introduction

1.1 Tackling health inequalities in access, experience and outcomes and improving population health are core aims of an ICS and central to our agreed system purpose in NEL.

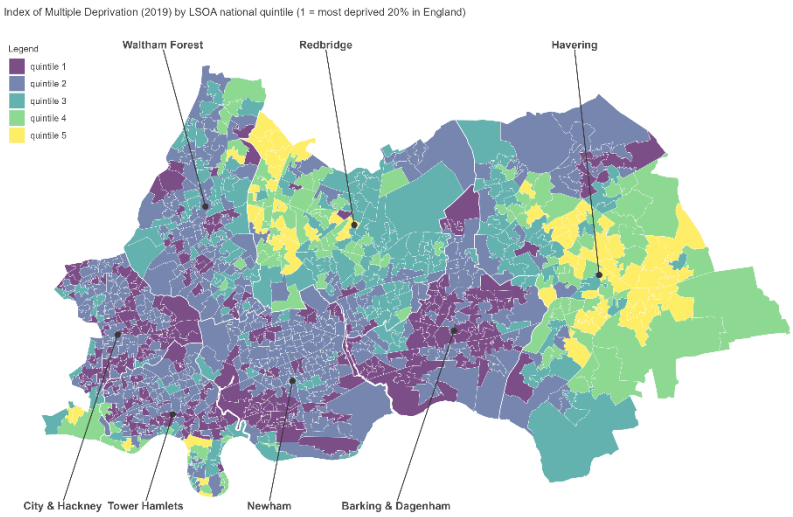
1.2 Tackling health inequalities was identified as a key cross-cutting priority in our first Integrated Care Partnership (ICP) Strategy published in January 2023 with the full support of all of our Place Based Partnerships and Health and Wellbeing Boards. This includes a focus on two critical dimensions for tackling health inequalities in NEL: poverty and ethnicity.

1.3 Agreement was also reached through our strategy to focus on the following 'underserved' groups across NEL: people who are homeless including refugees and asylum seekers; people with learning disabilities and autism; and informal carers. Co-production was identified as a key to all of our work on tackling health inequalities.

1.4 To support a 'deep dive' discussion at the ICB Board, this paper provides context to the work on health inequalities in NEL, sets out the roles of and opportunities for different parts of the system and highlights some of the progress that has been made as a system so far. Some questions for discussion are included at the end of the paper.

2.0 Health inequalities in NEL

2.1 Our population in NEL experiences significant health inequalities, and has worse health outcomes than the rest of the country across many key indicators.[1] Poverty and deprivation, which are key drivers of health inequalities, are widespread across all of our places in NEL and as such we have committed to taking a 'poverty lens' to our work as a system.



2.2 Likewise, more than half of our population in NEL are from an ethnic minority group. Ethnic inequalities in healthcare access, experience and outcomes are longstanding problems rooted in experiences of structural, institutional and interpersonal racism. Taking an anti-racist lens to all of our work in NEL is at the heart of our work on

[1] See NEL Population Health Profile for key population health outcomes in NEL compared to London/England.

health inequalities and a commitment to taking an anti-racist approach has already been agreed at the system level.

2.3 Furthermore, there is significant unmet health and care need in our communities that is not being identified or effectively met by current services, leading to worsening health and poorer health outcomes for these individuals. Unmet need is not equally distributed, and contributes to health inequalities within the population.

2.4 COVID-19 and current cost of living pressures have exposed and exacerbated existing inequalities and have a disproportionate impact on disadvantaged communities and underserved groups. For example, people with learning disabilities had more than a four times greater risk of death during the first wave of the pandemic in some NEL boroughs, compared to the general population. Whilst great efforts were made during COVID to provide accommodation to those that experience homelessness we know that the cost of living crisis across London has had a significant impact. Over the last year NEL has seen a 22% increase in those sleeping rough and approximately a third of those are new to sleeping on the street due in the main to cost of living pressures. The health impacts of these wider factors have a disproportionate impact in areas with high levels of deprivation and diversity such as NEL.

3.0 Dimensions

3.1 Tackling health inequalities is a cross cutting theme within our ICP strategy because reducing health inequalities requires sustained action by all parts of our system and across all of our work. The ICP strategy identified ways in which inequalities can be addressed within each of our four system priorities and underlined the importance of co-production in our approach.

3.2 The strategy also identified ways in which equity can be embedded across all aspects of our system including the way in which resources are allocated and the actions individual organisations can take to address wider determinants of health as anchor institutions, for example. Some inequity remains outside our direct control, for example, the wide variation in the public heath grant received by local authorities across NEL or the underinvestment in infrastructure given the size of our current population and the significant expected growth.

3.3 Making a meaningful impact on reducing entrenched health inequalities requires a long-term approach. There is work underway to design a new system planning process and as part of this an outcomes framework incorporating population health outcomes will be developed in time to inform the 24/25 planning cycle starting in Autumn 2023. Population health outcomes will not transform overnight but an outcomes framework will enable the board to agree what success looks like for our system and to track progress over time. Crucially it will enable us to ensure that our transformation programmes are better aligned to agreed population health and inequalities goals building on the success measures outlined in our strategy.

3.4 Coproduction with local people and communities and utilising community assets are critical to any approach for tackling health inequalities and there are many examples of innovative practice at the local level across NEL as well as areas where we need to strengthen our approach. Equally, there are many cases where there are well-established, highly evidence-based solutions in place and the issue has been ensuring reliable and sustained funding particularly in relation to the voluntary, community and social enterprise sector (VCSE).

3.5 Health inequalities are driven by wider social and economic inequalities, and addressing these 'wider determinants of health' is led by local authorities and the VCSE. Place-based partnerships involving the VCSE, local authorities, local people and NHS providers are well placed to lead and deliver our ICS ambition to reduce health inequalities, as they know their local populations and bring together the key partners whose action on health equity (including the wider determinants of health) can make a difference.

3.6 Place based partnerships across NEL have been convening partners at place to develop the infrastructure and local partnership arrangements for tackling health inequalities. Waltham Forest, for example, commissioned the Marmot team at the UCL Institute of Health Equity to review health inequalities in the borough and to come up with recommendations for action across sectors and the wider system in NEL. This has supported the development of local multi-sector collaboration including a common and granular understanding of local priorities and action on specific recommendations.

3.7 In addition to being partners in the full range of local place-based work, health and care providers have a direct responsibility for improving equity in access, experience and outcomes and ensuring their services are relevant and trusted by all of our diverse communities in NEL. Co-production with service users and patients ensures services are personalised and focused on what matters to them.

3.8 Providers also have a role as anchor institutions, using their power as large organisations to address the wider determinants of health e.g. through employment of local people or increasing social value in procurement. A NEL Anchor Network convenes leads from places and provider organisations across NEL also connecting to the range of London-wide activities on this agenda which includes a current focus on working towards adoption of the London Living Wage. East London NHS Foundation Trust (ELFT) is the first trust to partner with the Marmot team to understand how best an NHS Trust can implement programmes of work to address the wider determinants of health and work to tackle inequalities.

4.0 Highlights of our work in NEL

4.1 At the system level we have secured a commitment to allocate £19.8m funding over three years for tackling health inequalities in NEL. The three-year commitment provides a greater degree of certainty particularly for VCSE partners who are so critical to this work.

4.2 Of this funding, 85% has been allocated to place-based partnerships for a range of initiatives to support local action on health equity led by a broad range of ICS partners. 8% of the funding will support a shared ambition across NEL (potentially a minor ailments scheme to provide free medicines, wider support and advice to underserved groups who are struggling with the cost of living increase) and 7% will be used for the development of a NEL Health Equity Academy as described below.

4.3 There are many great examples of work within places some of which have been enabled by the dedicated funding allocated to place based partnerships. Evaluation of this work is being supported through a system-wide community of practice which also provides the opportunity for shared learning and support. Some examples of placed based work are listed below and there are also more examples in Appendix 1:

- A Money Hub aiming to maximise benefits uptake in City and Hackney

- A new weight management programme in Havering tackling the disproportionally high number of overweight or obese children aged 5 to 11 in partnership with schools in the most deprived parts of the borough
- A Health Engagement Bus in Redbridge taking services out to particularly underserved communities
- A work placement programme in Tower Hamlets which offers underemployed young women from Bengali and Somali backgrounds paid employment at Barts Health with the aim of gaining work experience and hopefully transitioning into full time employment
- Development of pop up locality-based community offer in Thames View in Barking and Dagenham, offering 'no appointment' GP consultations, triage to effective community responses and appropriate follow up, led by the voluntary and community sector and primary care.
- The funding has also been used to provide Community Chests for social prescribing in all of NEL places to support access to resources for the local VCSE.

4.4 Core20Plus5 provides the national framework for ICSs and includes specific actions relating to five key clinical service areas each for adults and children. A work programme is in place across each of these clinical areas in NEL – more details and examples are provided in Appendix 2.

4.5 There is also a range of work being undertaken in NEL to improve the use of data to tackle inequalities in access to healthcare. A dashboard to assess equity in our elective waiting lists has been developed, and is being expanded to cover other services to understand where action is needed. Reviews of 'Did Not Attends (DNAs)' and 'Was Not Brought' rates, and of emergency attendances, are also being conducted by equity characteristics. This will highlight where unwarranted variation exists and enable local teams to understand and take action to reduce inequalities. Assessing inequalities in waiting lists has already led to the prioritisation of people with learning disabilities for surgery at Barts Health.

4.6 At the system level greater support for the development of a Population Health Management (PHM) approach is also being resourced within the new ICB structure. PHM is a methodology for using data and insights to drive more preventative and proactive approaches to reducing inequalities within particular population cohorts. Support for health inequalities quality improvement work is also being enhanced with an initial focus on supporting our PCN health inequalities clinical leads.

4.7 In line with the focus on underserved groups set out in the ICP strategy, new models of care are being developed for people who are homeless or rough sleeping including hospital step down support, mental health support and primary care. There has been a significant increase in refugees and asylum seekers, and we are investing in outreach to support the initial assessment of need and GP registration within contingency accommodation alongside other support such as developing a NEL Outbreak Policy and sharing learning and best practice. Our ambition to become the second ICS of Sanctuary underlines our commitment to support for refugees and asylum seekers in NEL.

4.8 The Mental Health and Learning Disabilities and Autism Provider Collaborative is working innovatively with local people to co-produce plans for improving services. Their work to reduce inequalities for people with learning disabilities and autism includes a focus on the uptake of annual health checks; NEL ICB has continually met the 75% target but will be considering ways of measuring the quality and impact of these checks. City and Hackney is also piloting the annual health check for autistic

people. Implementation of the STOMP project (Stopping the Over Medication of People with a learning disability and autistic people) is also a key objective to reduce health inequalities; the project now has two dedicated pharmacists who have achieved great results in reducing the number of people on psychotropic medication and reducing the side effects associated with these medicines. A huge amount of work in this space is overseen by the LeDeR programme (Learning from lives and deaths), which requires that the deaths of every person with a learning disability over the age of 4, and every autistic person over the age of 18, must be reviewed by the ICB. The resultant action plan from these reviews is published every year and provides further details of the work being undertaken to improve the quality of health and social care services for this cohort of people.

4.9 Each Place Partnership has led or contributed to the development of joint Carers' Strategies which both celebrate the amazing contribution of informal carers to the health and care economy but also seek to better support informal carers to carry out their caring responsibilities and to remain healthy and well. We know that carers are less likely to access health and care services in a timely way and to experience social isolation, whilst focusing on the needs of the cared for person, we know also they are more likely to be women and to be supporting more than one dependent at any one time. Across north east London, a community of practice is being convened to enable us to work alongside carers and their advocates, to build relationships between those working on carers' issues, and to ensure we create the framework which best enables delivery of the ICB duties whilst complementing the significant local activity already underway.

4.10 The launch of a new Health Equity Academy is planned at a system wide event hosted by our Chair Marie Gabriel and Chief Medical Officer Paul Gilluley. The Academy will equip health and care staff including those working in the VCSE with the knowledge, skills and confidence to reduce health inequalities in their work. The academy will also provide a focal point for our anchor network and for driving a more upstream approach to planning and delivery of care through the development and embedding of PHM as above, as well as providing a repository for evidence and case studies and other shared learning opportunities to support everyone to accelerate progress in this work.

4.11 The work with the VCSE to co-create a VCSE Collaborative is moving forward into the next stage of development with the agreement to appoint a development lead, hosted by Tower Hamlets CVS. This role will support the sector and the ICB to determine the infrastructure required to ensure an effective VCSE Collaborative is shaped for north east London, recognising the diversity of the sector and the range of interventions and activities which they lead and deliver.

4.12 The Working with People and Communities Strategy signalled the ambition of NHS North East London to develop and embed co-production across the geography and various partnerships established and in development. This has led to significant levels of activity and a real focus on co-production running through our approaches both strategically and operationally. We have brought together partners in co-production round tables during the year and will continue to do so as we shape a high level organising framework for co-production to co-ordinate our activity and our models. The Big Conversation is touching all parts of our communities across north east London with targeted work to ensure that we build the relationships which lead to engagement in co-production activity across the piece.

5.0 Conclusion

5.1 This report provides an overview of health inequalities in NEL including how we are working to address them across the system, and where the priorities and opportunities are moving forwards. Sustained action from all partners within the ICS is critical to making a tangible difference for our population.

5.2 Proposed questions for discussion:

i. How do we ensure tackling health inequalities remains a priority within NEL across the whole of our system leadership particularly as the pandemic becomes more distant?

ii. How do we leverage more opportunities across our £4bn health economy recognising that our £20m three-year programme alone will not deliver the scale of change we need?

iii. What more can we do to empower places to make a difference to population health and health inequalities for their local populations?

iv. What support / levers are needed to ensure providers / provider collaboratives can focus on population health and inequalities?

v. Where can the system add most value in making a meaningful impact on health inequalities and what is the right approach to scaling up given the local nature of this work?

6.0 Appendices

- Appendix 1 – More highlights from work in NEL Places
- Appendix 2 – Highlights from NEL work to reduce healthcare inequalities within the Core20Plus5 national framework

Appendix 1 – More highlights from work in NEL Places

- In Havering, advice workers have been recruited to provide advice, support and information to over 50s with regards to uptake of benefits. So far, 268 clients have been referred to the service, and advice workers have helped clients to access an estimated £627,000 per annum to date. Onward referrals and networks have also been key in making a difference to client lives.

- Newham Central 1 Primary Care Network (PCN) were awarded £40k from the Complete Care Communities Programme for a project to reduce knife crime, working collaboratively with the voluntary sector and local schools. A multidisciplinary screening tool to identify 11-14 year olds at risk of committing knife crime was developed and management fees for a voluntary organisation link worker funded. The project has a strong focus on collaborative working, especially with local secondary schools. The outcomes from the project provide opportunity for shared learning across the system.

- In Barking and Dagenham, practices have been reviewing searches by the Clinical Effectiveness Group (CEG) to find undiagnosed patients with symptoms of Chronic Obstructive Pulmonary Disease (COPD), Diabetes, and Cardiovascular Disease (CVD) and inviting patients for screening. Case finding is resulting in an increase in patients on the disease register, for example 718 cases of hypertension and 215 new cases of Chronic Kidney Disease have been diagnosed.

- Two machines for intraoperative cell salvage (a technique for blood replacement in which red blood cells lost during surgery are recovered, washed and prepared for safe re-infusion to the patient) have been purchased for the obstetrics ward in Newham University Hospital, and training on their use is complete. It is expected that there will be a high take up relating to ethnic minority women in c-sections, and for Jehovah Witnesses that currently cannot be supported at the hospital.

- Targeted support for employment and physical health checks for people with Serious Mental Illness (SMI) is being funded in City & Hackney, including Individual Placement and Support employment schemes, Improving Access to Psychological Therapies for people with long term conditions, and outreach for SMI physical health checks.

- Havering is a pilot site for the Core20Plus Connector Programme in NEL. Connectors are people with influence in their community who can engage with local people and link them with a range of health and wider services to help improve their physical and emotional wellbeing. This programme is focused on a small area of Havering, Harold Hill, one of the most deprived 20% areas in the country. A funded core connector has recruited volunteer connectors, who have engaged and supported a large number of local people since the pilot was established in 2022.

- Waltham Forest LBC, working with HEET, a not-for-profit fuel poverty charity, has so far supported 78 households with long term health conditions who are impacted by living in cold homes. The project is targeted at fuel poor households, providing free energy saving advice, income maximisation support, energy saving advice and the fitting of energy saving measures as required. The package of support includes a home visit; installation of small measures such as new boilers, new heating controls, loft insulation, secondary glazing, loft insulation; and the treatment of mould. The result has been better energy efficiency, warmer homes, and an observed reduction in energy bills averaging £226 per household.

- NEL partners across the NHS and children's social care have developed a project to provide care leavers with a pre-paid prescription card so that those who are students or on low incomes can access the medications they require as this has been identified by care leavers as an issue exacerbated by cost of living.

- Barts Health are working with local GP practices to improve digital health literacy skills and competency for elderly patients. The GP surgeries identify and recruit patients that will benefit from digital upskilling, and a large pool of volunteers including with knowledge of community languages will be created.

Appendix 2 – Highlights from NEL work to reduce healthcare inequalities within the Core20Plus5 national framework

- Targeted campaigns and projects to reduce inequalities in cancer prevention, awareness and screening include the Muslim Sisterhood Cervical Screening campaign focused on improving uptake of cervical screening for young Muslim women through dispelling myths and education on benefits of screening. The It's Not a Game campaign, in collaboration with Leyton Orient FC focuses on raising awareness of cancer symptoms in men over 40, with a particular focus on prostate cancer and targeting black men as a higher-risk population.
- Tobacco Dependence Treatment Services have been mobilised across all of our NHS Trusts in NEL, as well as support for seamless pathways into local communities and wider support for NEL to be Smokefree. Smoking is one of the leading causes of health inequalities.
- NEL Local Maternity and Neonatal System (LMNS) have been working with Healthwatch and Maternity Mates to engage with staff, advocates and service users of maternity services to understand their experiences, feedback and suggestions on what could be done differently to improve outcomes for those from Black, Asian and Mixed Ethnic backgrounds and those from deprived areas.
- The NEL CVD prevention plan is based on taking a whole system approach using population health data to gain a full understanding of the health inequalities experienced across our places and understand the issues that matter to specific communities within them. This information is being used to tailor approaches that meet this need and improve prevention and progression of CVD in the local population. For example, we are working with the Accelerated Access Collaborative In-HiP to provide screening for Atrial Fibrillation in underserved populations in Barking & Dagenham and in Newham by going into the community to case find in places of worship and community centres. This is led by the NEL cardiac clinical network.
- Babies, Children and Young People are a system priority in our new integrated care partnership strategy and we are delivering on many aspects of the new Core20Plus5 CYP framework. This includes: improving access to diabetes technology for children in BHR as evidence shows that families from more deprived areas are less likely to access medical technology to help manage their child's condition; a training programme on the impact of air quality on childhood asthma provided to health professionals across NEL, and a series of animations in community languages for parents and carers on air quality and steps they can take to mitigate the impact on children; and working with place based partnerships to trial child health clinics to improve integrated care for the most vulnerable children to ensure their needs are met.

North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	Quality Oversight and Support Report
Author	Polly Pascoe, Associate Director Quality Development
Presented by	Diane Jones, Chief Nursing Officer
Contact for further information	Chetan Vyas, Director of Quality, chetan.vyas1@nhs.net
Executive summary	North East London Integrated Care Board has a statutory responsibility to improve the quality of services across north east London. We do this through oversight of service quality and the provision of support to service providers where quality, safety or safeguarding issues are identified. This report aligns with the Quality Assurance quadrant of the NEL Quality Management System and should support the Board to answer the question "*are we delivering high quality care?*". To answer that we have discussed bringing quality and performance in to a shared report. There are plans to hold workshops with quality and performance leads in the autumn. The quality, safety and safeguarding teams have been providing support to services within NEL, across the following themes: • Acute Care (Urgent and Emergency Care, Administration Incidents and Two Week Waits for Cancer Referrals) • Community Care (Urgent Treatment Centres • Mental Health (Patient Deaths, Violence and Aggression, Administration and Safeguarding) • Primary Care (CQC Inspections) • Social Care (CQC Inspections, Refugees and Asylum Seekers, Independent Health Assessments and Review Health Assessments) In relation to regulatory activity, an inspection of four East London NHS Foundation Trust wards was undertaken in February 2023 and the findings were published in June 2023. A summary of the findings can be found in section 3 of this paper.
Action required	The Board are asked to note the content of the report and discuss areas for reporting improvement
Previous reporting	None
Next steps/onward reporting	Report to become a regular item on the NHS North East London ICB Board agenda with recommendations for improvement suggested by members of the Board.

Conflicts of interest	No conflicts known in relation to the content of this paper
Strategic fit	The ICS aims does this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access
Impact on local people, health inequalities and sustainability	The content of the report details works undertaken to support services in improving the level of care local people receive, address inequalities and remain sustainbale. There are no further impacts as a result of this paper.
Impact on finance, performance and quality	The content of the report details works undertaken to improve the performance and quality of service across north East London. There are no further impacts as a result of this paper.
Risks	The content of the report details known risks and issues at a local and system level in relation to quality. There are no further risks as a result of this paper.

1. Introduction

North East London Integrated Care Board has a statutory responsibility to improve the quality of services across north east London. We do this through oversight of service quality and the provision of support to service providers where quality, safety or safeguarding issues are identified.

This report aligns with the Quality Assurance quadrant of the NEL Quality Management System and should support the Board to answer the question "*are we delivering high quality care?*". The purpose of this report is to provide a brief overview of the quality oversight and support work underway across north east London. This paper presents a thematic summary of quality issues and describes the work underway within the ICB to address them.

More information on how the ICB undertake quality oversight and support can be found in the NEL ICB Quality Escalation Framework, which builds on the National Quality Board Risk Response and Escalation Guidance.

This report provides a localised 'experience-based' perspective on quality in north east London; issues and responses to them are identified from, and responded to at, 'the frontline', through a range of processes including serious incidents, regulatory activity, service inspections and feedback from patients/staff. It is the first of its kind presented to the Board and we welcome direction from its members regarding areas for improvement to ensure the report is fit for purpose.

Work is underway to develop a system 'data-driven' perspective on quality, ensuring the Board have a full view of the quality of care across the Integraeted Care System (ICS). Further information regarding this can be found in Appendix A.

2. Quality Oversight and Support Summary

The information in this report is themed: first by care area (e.g. acute / community / social care) and second by service/issue/activity type.

2.1. Acute Care

Urgent and Emergency Care

Barking and Dagenham, Havering, and Redbridge: Ambulance handover at emergency departments is a significant issue within north east London, with Queens Hospital (Barking, Havering, and Redbridge NHS University Trust (BHRUT)) experiencing the worst delays in London with no improvement, despite signs of recovery elsewhere in London. NEL Urgent Emergency Care Board have been leading on actions to support improvement across the system and a specific BHR Urgent Emergency Care Board has been stood up to address these issues locally.

Administration

Barking and Dagenham, Havering, and Redbridge: The quality team are currently supporting BHRUT in addressing a serious incident relating to the malfunction of their EPRO dictation system, which led to a failure to issue nearly 80,000 GP letters. Work is underway to reduce the current backlog of 43,000 GP letters, with the remainder managed through business as usual processes. A clinical validation exercise has, to date, identified 405 unissued letters that required clinical review, and of these, 282 clinical harm reviews have been completed, with no harm identified. A Serious Incident Investigation is in progress.

Homerton: The Quality and Safeguarding teams are currently supporting Homerton in addressing a serious incident relating to the administration-led discharge (discharged due to repeated Was Not Brought (WNBs) or appointment cancellations) of 3782 without safeguarding/clinical review. Of these, 30 patients were identified as having known safeguarding concerns and paediatric safeguarding professionals are undertaking reviews of these to explore potential safeguarding issues. A harm review will also be undertaken. Immediate actions implemented by the Trust include the clinical review of all administrative-led discharges prior to the discharge being enacted.

Two Week Wait Cancer Referrals

Tower Hamlets: There is currently a six to eight week wait time for appointments across Ears, Nose and Throat, Head and Neck, and Urology, in Royal London Hospital. Several factors have contributed to this including delays in the triage of referrals and a shortage of doctors. A clinical harm review is underway to assess if any patients on the waiting list have suffered harm as a result of the delays.

2.2. Community Care

Urgent Treatment Centres (UTCs)

Barking and Dagenham, Havering and Redbridge: The Partnership of East London Cooperatives (PELC), who deliver UTCs in Barking and Dagenham, Havering and Redbridge will be reinspected by the CQC throughout June 2023; we are now awaiting the report. Feedback from PELC and the CQC suggested improvements had been made across a number of areas that were highlighted in the previous report. The ICB Quality Team continue to use the Enhanced Surveillance approach (as outlined in the National Quality Board Quality Risk Escalation

guidance) in working with PELC to support improvements against their CQC action plan. The ICB has provided inspection readiness support to PELC, undertaking with mock visits, and offering advice and guidance regarding the presentation of evidence and information. A post CQC learning discussion between PELC, and NHS NEL planned.

Redbridge: NEL Quality Director, NEL Quality Leads and NEL Designated Professional for Safeguarding have been working closely to develop and offer a package of support to PELC to address safeguarding issues identified as a result of findings of serious incident investigations and CQC inspections.

2.3. Mental Health

Patient Deaths

Outer London: North East London NHS Foundation Trust (NELFT) has responded to two Regulation 28 Reports issued by the coroner. The ICB is working with NELFT to gain assurance and action plans detailing how the Regulation 28 Report recommendations will be addressed have been requested.

Inner London: East London NHS Foundation Trust (ELFT) has reported two serious incidents in May involving inpatient deaths. Both cases have been referred to the coroner and related serious incident investigations are underway.

System working

A NEL Mental Health Crisis Improvement Network has been established with our provider collaborative. This group, which combines clinical, operational and service user leadership from a variety of providers are driving forward a programme of improvement work across the whole pathway, and building opportunities to share learning and good practise.

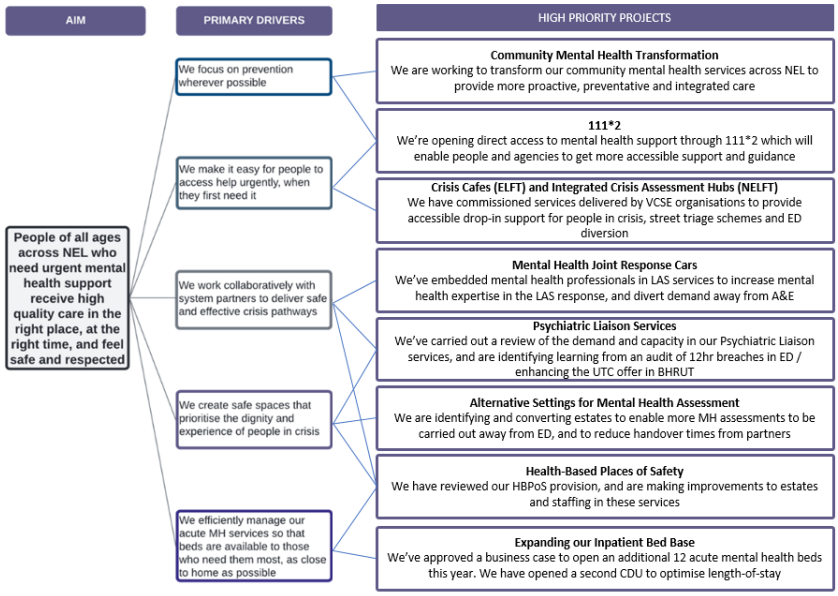
Below outlines the work that is already underway to look at addressing Mental Health patients presenting into NEL Emergency Departments:

What are we doing already?

MH Crisis Improvement Network

We have established a NEL Mental Health Crisis Improvement Network with our provider collaborative.

This group, which combines clinical, operational and service user leadership from a variety of providers are driving forward a programme of improvement work across the whole pathway, and building opportunities to share learning and good practise.



What are we doing already?

Active projects		
Projects	**Update**	**Impact**
Expanding acute MH bed base	• Business Case agreed to open additional acute MH beds at Goodmayes. • Additional Project Manager in place • Recruitment planning underway • Capital work required, application under review with response due end June	• Additional 12 male acute beds forecast to reduce occupancy by 5% and improve flow
NHS 111*2	• 'Go-live' set for 1st April 2024 • Operating model confirmed at 20th June MHLDA Programme Board • Business Case under redevelopment – hoping to bring to August Programme Board	• Modelling forecasts that this service will receive 85k calls/year in NEL
Health Based Places of Safety	• Review carried out of NEL HBPoS estate and service, reaching the following recommendations: 1) Open 3rd suite at Goodmayes (requiring capital works and increase to staffing capacity) 2) Safety alterations to C&H suite (requiring capital works and increased staffing capacity) 3) Close Newham suite (subject to consultation process) • Plan to reform the NEL HBPoS Steering group to lead and coordinate changes	• Main focus is improved safety and experience of care – but additional staffing aiming to improve flow too
Right Care, Right Person	• Information sheet on MH crisis and S136 for police officers circulated • Exploring opportunity to develop Street Triage model where not already in place • Planning meeting booked with police leads to scope out RCRP delivery plan	• Expectation through RCRP for 1hr handovers

Active projects		
Projects	**Update**	**Impact**
Psychiatric Liaison Service review	• MH UEC case note audit carried out for 30 people who waited over 12hrs in each A&E. This has been fed back into teams and plans to initiate improvement work • PLS Core 24 review carried out, data shared with service leads, for wider circulation in July • Flow event postponed to September (Date TBC) to reflect on learning from these for each site and to share how its being used	• Audit highlighted process delays from ED assessment to referral to PLS (9hrs average at Queens), others from DTA to bed availability (17hrs at Newham)
MH Joint Response Cars	• 3wte b7 Mental Health Practitioners now in place for working in NEL MHJRCs, with contract in place for 23/24	• Increase in activity in April & May and appear to divert away from ED (only 5% calls conveyed to ED)
Clinical Decision Unit capacity	• Currently 20 beds at Goodmayes Hospital, with consideration being given to further expansion	• LOS data demonstrates reduced LOS on CDU (from 45 days to 8 days). Further review underway of wider impact
S12 App	• Unclear whether subject to Clinical Safety Review – S12 Solutions lead having follow-up with ICB Lead to confirm plan	• Expected to reduce some delays and inefficiency booking doctors
Raybould Centre (C&H)	• Service has had a 'soft launch' – money in place and facility ready, recruitment underway. Not yet operational beyond 6pm.	• Expected to enable more assessments to happen away from ED

<u>Violence and Aggression</u>

City and Hackney: The Quality Team have been supporting ELFT following an incident of violence and aggression on Bevan Ward (male Psychiatric Intensive Care Unit), which impacted several staff members and service users. Those impacted by the incident have been supported and ongoing work is underway in ELFT exploring staffing, morale, clinical supervision, leadership, and patient wellbeing.

<u>Safeguarding</u>

Newham: The ICB Safeguarding Team has been working with the Adult Safeguarding Board for London Borough of Newham to close two outstanding actions from the safeguarding concerns process for Cygnet.

Administration

Newham: Cygnet have had two incidents relating to service/patient administration; one relating to communications involving newly admitted patients, a female mental health inpatient unit, and a failure to notify the ICB of serious incidents. The ICB have liaised with a range of agencies, including other ICB commissioners to resolve these issues and identify ways to monitor their solutions moving forward.

2.4. Primary Care

CQC Inspections

Waltham Forest: The CQC reinspected the Crawley Road Medical Centre in May 2023; the Quality Team are awaiting publication of the report. The CQC were due to reinspect Francis Road Medical Centre following the ending of their six months special measures period, however this inspection has been stood down due to the CQC restructure. The CQC has received a number of whistleblowing complaints related to the practice and the CQC Medical Directorate and NEL Primary Care and Medical Directors are liaising regarding these issues.

Redbridge: A CQC inspection in August 2022 rated Hainault Surgery 'Inadequate', following which, the practice was put into special measures. The practice submitted related action plans and a CQC re-inspection in January 2023 noted a range of improvements had been made. The CQC will be returning to undertake a full review in upcoming months.

Barking and Dagenham: The CQC published their 'Inadequate' rating of Salisbury Avenue Healthcare in May 2023. The ICB Quality Lead has been working jointly with primary care commissioners, medicines management, safeguarding, and infection control teams to support the GP in putting together an action/recovery plan to address concerns raised in their inspection. CQC have requested that a remedial plan be submitted for all issues noted under "safe" by 1 July 2023.

2.5. Social Care

CQC Inspections

Barking and Dagenham: London Borough of Barking and Dagenham was part of a three-week thematic review of alternative provision. This visit was jointly led by Ofsted and CQC. An ICB debrief and lessons learnt session took place in May 2023 and a further one is anticipated with the partnership. A NEL inspection readiness group is in place and key areas of focus have been identified for the system and at place.

Waltham Forest: Normanshire Supported Living Services and Leyton House each received 'Good' CQC ratings in March 2023 and April 2023 respectively. Verity Healthcare received a 'Requires Improvement' rating in March 2023.

Independent Health Assessments and Review Health Assessments

Barking and Dagenham and Redbridge: Concerns have been raised regarding the quality of Initial Health Assessments (IHAs) in Barking and Dagenham and Review Health Assessments (RHAs) in Redbridge. The ICB is working closely with NELFT to undertake audits of both IHAs and RHAs. There is a proposal for a joint audit and ICB Designated and Named Doctors will be supporting this work and a request for an external independent review of the complex data. An ICB and NELFT safeguarding Away Day took place on 10 March 2023 and there is a plan for a focussed session Looked after Children in June/July 2023.

Tower Hamlets: There is insufficient clinical capacity to undertake IHAs and RHAs and provide reports due to reduced Designated Professional capacity as a result of vacancies. Immediate cover has been achieved by Barts Health NHS Trust who has employed locum doctor/s to fill the gap and the NEL ICB Peer Review Group has secured additional limited capacity with two local GPs. The NEL ICB Peer Review Group workstreams are reviewing workforce, performance and delivery models across NEL ICB system.

City and Hackney Ongoing late notifications of IHAs has been escalated appropriately at place. Capacity for the IHA clinic is compounded by doctors' availability, provision of allocated clinic slots and the Named doctor functions (covers adoption and fostering).

Waltham Forest: One risk identified was that 45 IHA reports had not been shared with the Local Authority. The issue has been raised with NELFT and Datix, and an internal investigation is underway. The Standard Operating Procedures reviewed for both NELFT and the Local Authority included for administrators to be more alert to missing reports.

Actions taken

- Sessions have been held regarding improving partnership working across the Looked after Children workforce with between NELFT and NHS North East London
- Continuous review of outcomes achieved for Looked after Children (LAC)
- Escalation to Barking and Dagenham Executive Leads
- Focussed discussion in Safeguarding Partnership meetings and Corporate Parenting Boards
- Safeguarding audit in progress for completion in August 2023 - NEL Designated and Named doctors to support NELFT with scoping and terms of reference for medical prescribing audit which is to be completed in Q3 of 2023/24.
- Continuous Improvement approach adopted through Peer Reviews, supporting LAC workforce undertake assessments, and, commissioners reviewing capacity and demand
- All outstanding notifications shared with Waltham Forest Local Authority
- Audit Programmes
- System Looked After Strategy being developed

Outcomes of all of the above will be reviewed to determine if a second System session is to be held.

3. Regulation

East London NHS Foundation Trust

CQC undertook a focussed inspection of four acute wards for adults of working age and psychiatric intensive care units (two were in North East London and the other two across Luton and Bedfordshire) in February 2023 and published their findings in June 2023. Aspects of the safe and well-led domains were looked at but only the safe domain was rated. It was rated as 'Requires Improvement'. The overall rating for the Trust remains 'Outstanding'.

The CQC found:

- Ward environments were safe and clean and the wards had enough nurses and doctors
- Escalation processes for staff when they were short staffed or needed additional staff had improved
- Service improvements had taken place in a timely manner as a result of learning from serious incidents
- On all wards the observation, ligature risk mitigation and patient search processes had improved, supported by the development of a suite of online training covering suicide prevention, ligatures, observations, and patient searches to support staff in learning lessons from previous incidents
- Most staff were well informed about incidents
- Staff knew about previous serious incidents going back several years
- Senior staff investigated incidents thoroughly and patients and their families were informed about incidents and involved in these investigations
- The trust worked closely with family members and offered family members the option to feed into the service improvement and development processes. This had a powerful impact in understanding and how the application of operational processes played a vital role in patient safety.

However:

- The inspection identified a breach in Regulation 12, safe care and treatment. The trust did not always meet its targets for compliance with mandatory training.
- This inspection also identified a breach in Regulation 18, staffing. Managers did not support all staff through regular, constructive clinical supervision of their work. The services' supervision completion rates did not always meet the trust's supervision target.
- The trust did not always conduct and record the environmental checks to ensure the safety of ward environments to a consistently high standard
- The trust did not always ensure that serious incident action plans were updated to reflect further changes in the actions needed to carry out the changes successfully
- The trust did not always ensure that actions from serious incident reports were fully discussed between staff responsible for delivering those actions and the senior managers and central serious incident team to ensure actions were correctly interpreted.

The ICB Quality Team are working with ELFT to understand progress against their action plan.

Appendix A

1.0. Introduction

1.1. The aim of the System Quality Dashboard is to provide system-level oversight of core quality metrics, supporting the Quality, Safety and Improvement (QSI) Committee and the NHS North East London ICB Board to remain well-informed and responsive when considering the quality of the care delivered across North East London.

1.2. This paper provides an overview of the work undertaken to date to develop a System Quality Dashboard that will be presented to the QSI Committee and the NHS North East London ICB Board. It provides an update on current thinking and the challenges that currently impact the delivery of such a report.

1.3. The NEL Quality Management System (QMS), details how we plan, assure, improve, and control quality across the partnership. In simple terms, the QMS enables us to ask, of the system and each of its partners, four key questions:

1. What is high quality care?
2. Are we delivering high quality care?
3. Are we effectively improving our services?
4. Are we addressing risks to the level of care provided?

The System Quality Dashboard seeks to support members of the QSI Committee and the NHS North East London ICB Board to explore and answer questions two through four. It will present the corresponding 'top-down', 'data-driven' view of quality across NEL ICB that accompanies the 'front-line', 'experience-based' perspective of quality as provided in the recently presented Quality Oversight and Support Report.

1.4. One of our quality principles is to develop an open culture and learning system across the ICS. The NEL Learning Cycle (learning before, during, and after) supports us to develop processes and products that support us to be:

- **Well-informed** – our service users should have confidence in the fact that before we act, we fully consider the impact of our potential actions on individual, community, and system outcomes and equity.
- **Responsive** – service users should have confidence that we are effectively monitoring our interventions and acting in a timely manner, when standards drop below what is expected.
- **Reciprocate** – service users should have confidence that we are working together in their best interests, sharing knowledge openly, and valuing collaboration over competition.

The System Quality Dashboard will support members of the QSI Committee and the North East London ICB Board to remain well informed and ensure the work of our leaders remains responsive to changing contexts and needs.

2.0. Overview of the Quality Dashboard

2.1. The System Quality Dashboard is intended to provide be a data-driven hybrid report, with core metrics displayed and commentary developed related to our four system quality priority areas (babies, children and young people, long-term conditions, mental health, and workforce).

2.2. The dashboard will be a data-driven hybrid report, with narrative generated in order to explore both negative and positive exceptions to the quality of care we provide across the ICS. The report presented is an initial first draft, intended to demonstrate:

- The range of metrics currently available through the NHS Oversight Framework Metrics publications and other reports generated as standard by the central performance team;
- How these metrics might be grouped to enable an overarching understanding of Quality across the system;
- The ways in which data can be presented to demonstrate issues related to assurance, improvement, and control; and
- The work that will need to be done to ensure this report is accurate and enables conversation and action across the system.

2.3. The data within the dashboard will be presented in Statistical Process Control charts, which enable exploration of issues related to assurance (whether we are meeting targets), improvement (whether our actions are leading to demonstratable change) and control (whether our processes and systems are reliable and lead to the intended outcomes). The approach is in line with Measurement for Improvement and Making Data Count approaches.

2.4. The metrics included in this report will be primarily taken from the NHS Oversight Framework performance report, which is the core data set reviewed by those undertaking the annual NHS Oversight Assessments. Metrics have also been identified from existing reports developed by the central performance team and where possible, from the quality priority areas leads within the ICB. Metrics are discussed in more detail in section 6 of this paper.

2.5. Initial attempts to develop a first draft of the System Quality Dashboard identified a range of issues that exist in the use of currently available data and its impacts on accuracy and focus on quality. Significant further collaboration and development work is needed to ensure it is fit for purpose and enables our QSI Committee, Board, and wider ICS partners to be assured that they are acting on accurate and insightful information.

2.6. It is recommended at this stage further work is undertaken prior to the dashboard being presented to the Board and that this be delayed until the issues raised are, in the majority, addressed or clearly mitigated against.

3.0. Content

3.1. In January 2023, NEL ICB published its Interim Integrated Care Strategy, detailing within it four key system priority areas (Figure 1). The Board have committed to ensuring that within these areas, quality of outcomes are improved, and health inequalities tackled.

Figure 1: NEL ICB System Priority Areas

Babies, Children & Young People	Mental Health	Long Term Conditions	Workforce
• To provide the best start in life for the babies, chidlren and young people of NEL	• To improve the mental health and wellbeing of the people of NEL	• To support everyone at risk of developing or living with a long term condition in NEL to live a longer and healthier life	• To create meaningful work opportunities and employment for people in NEL now and in the future

3.2. NEL ICB also has its ten Quality Pillars, which have drawn on definitions and understandings of Quality produced and used by organisations such as the National Quality Board and the Care Quality Commission.

Figure 2: NEL ICB Quality Pillars

3.3. The extent to which a Quality Dashboard would explore each of these Quality Pillars will be a consideration the Board need to make in their decisions related to the content of Board meetings and related papers. Inspiration may be taken from our Quality Prompts, which nudge us to explore issues of quality further.

3.4. It is proposed in the first instance the Quality Development Team work with colleagues to develop a report that explores high level metrics in relation to the four quality priority areas.

4.0. Measurement for Improvement

4.1. Measurement for improvement differs from measurement for assurance, in which teams / services / systems are judged on their performance against targets, external baselines, or one another. Measurement for improvement seeks to explore whether the work undertaken within our systems leads to the intended outcomes.

4.2. Making Data Count is an initiative developed by NHS England to support those working in NHS organisations to develop and effectively implement the principles of Measurement for Improvement. The System Quality Dashboard is developed in line with the Making Data Count guidance and further guidance also supports decision-makers to better understand when and how to respond to the data presented.

4.3. Making Data Count makes the case for and demonstrates the use of Statistical Process Control as a method for exploring quality, making better decisions related to how to respond to issues related to quality and exploring the impact of improvement actions taken.

4.4. Statistical Process Control (SPC) is an analytical technique – underpinned by science and statistics, that plots data over time. It helps us understand variation and in so doing

guides us to take the most appropriate action. It is widely used to understand whether change results in improvement and whether quality is controlled. Statistical Process Control charts can also be used to provide assurance, demonstrating where performance does not meet intended targets.

4.5. The use of Statistical Process Control (SPC) charts can:

- Alert us to a situation that may be deteriorating;
- Show us where a situation/system is improving;
- Demonstrate how capable a system is of delivering standards or targets; and
- Detail whether our processes and ways of working are reliable and lead to expected results.

4.6. Currently, the Quality Development Team do not have the software or tools to develop a dashboard with steadfast assurance in the presentation and analysis of the date. Pilot reports have been developed utilising tools taken from the NHS England website; these tools require manual data entry which presents significant risks to the accuracy of this data entry and the risk of human error in this process, in addition to an unsustainable administrative burden on the team. Where the Board choose to move forward with this approach, a business case would need to be made for funding to identify and gain access to the correct software to do this work accurately and efficiently.

4.7. The approach is highly technical, with different SPC charts (and the complex formulas that sit behind them) relating to different types of metrics and measures. It is recommended that the lead on the development and presentation of such data is managed by colleagues in our analytics team(s) to ensure the data is presented in the correct way and the QSI Committee, and the Board, have confidence in the decisions made and actions taken based on this data.

5.0. Metrics

5.1. The current available metrics to include in this report are primarily taken from the NHS Oversight Framework performance report, which is the core data set used by those undertaking the annual NHS Oversight Assessments. Some metrics have also been identified from the broader range of reports routinely published by the central performance team. Again, these metrics are highly performance focused and, in most cases, do not provide a view of quality, focusing primarily on inputs and outputs of systems, rather than the outcomes they generate.

5.2. Data from the central performance team is also heavily NHS focused, with only a small proportion related to our local authority and/or integrated activity. This is a significant gap in relation to our ability to understand our work as an ICS, not just an ICB. Accessing data from local authorities can be a challenge that requires significant information governance and analytics support.

5.3. The data from the central performance team is however validated, meaning our confidence in the accuracy of the data is higher. The use of this data however causes significant issues in relation to measurement for improvement and making data count, as the requirements to process and publish validated data often means the data accessible is two to three months out of date at a minimum.

5.4. Discussions have been had with a range of leads for the system priority areas in order to discuss relevance of the metrics pulled from these sources. Feedback is as follows:

- There was considerable concern that these metrics are again, performance related and focusing significantly on input/output rather than quality of outcomes or inequalities. Leads spoken to were often able to identify and suggest more relevant metrics that could be used. These metrics were often collected at a local level (via submissions from services) and while therefore much timelier, questions arise to whether the use of non-validated data could lead to inconsistent or inaccurate reporting as numbers would change from month to month as validation exercises are undertaken.
- Initial conversations with programme leads also highlighted areas of concern in relation to duplication of reporting, particularly between performance and quality, and how the organisation will seek to consolidate these elements and streamline reporting. This will be a decision the Board would need to make.

5.5. Finally, in some cases relevant metrics did not exist, or were not collected regularly enough to promote a quality-focused, measurement for improvement way of reviewing the NEL context. Work may need to be undertaken to stand up additional data collection approaches across the ICB, particularly in relation to sustainability, leadership and governance, and inequalities and equalities.

6.0. Future development work

6.1. Work on the Quality Dashboard has paused due to the range of risks and issues highlighted above and the inability of the organisation to address these during the consultation process. Considering the capacity to undertake this work is already slim, questions arise as to whether post-consultation there will be the capacity within the organisation to undertake this work.

6.2. Where Board support is given to this approach, it is proposed the following work is undertaken:

- The Quality Development team will undertake learning sessions with each of the quality area leads and board members
- Work with each priority area lead will need to be undertaken to identify relevant metrics and explore appetite regarding risk of using non-validated metrics in order to explore issues in more depth and in a timelier way. Direction will be provided by the priority areas leads who will have a stronger understanding of which datasets in their area are more ‘trusted’ than others.
- Work with local authorities will need to be undertaken to ensure data-sharing can be undertaken between the ICB and our colleagues at place.
- Work will need to be undertaken to develop a directory of colleagues to ensure, where data indicates a cause for concern, the right people can be reached out to and have this discussion, enabling the narrative of the report to be developed quickly and with the most knowledge people.
- A business case will need to be developed to ensure the dashboard is being developed using the right technical and analytical tools
- Work with performance analytics to determine how best data presentation can be automated to future-proof the approach post-consultation.

North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	Month 3 2023-24 Financial Overview
Author	Steve Collins
Presented by	Henry Black, Chief Finance and Performance Officer
Contact for further information	henryblack@nhs.net
Executive summary	**Key Items** • The paper outlines the financial performance for the ICB and ICS, showing a year-to-date to June 2023 position with an adverse variance to plan of £8.3m for the ICB as part of a £41.8m adverse variance for the ICS. • The report includes a review of efficiency plans and impacts from inflation, staffing, industrial action and other operational pressures. • System risks have been considered, along with the on-going work in the development of a financial recovery plan. • In line with the operating plan and NHSE protocol the system is reporting a breakeven position at year-end.
Action required	• Note the contents of the report and the risks to the financial position.
Previous reporting	ICB Finance, Performance and Investment Committee.
Next steps/ onward reporting	Future financial and risk updates will be given to the ICB Board, ICB Finance, Performance and Investment Committee and the ICB Audit and Risk Committee.
Conflicts of interest	No conflicts of interest
Strategic fit	NEL wide plans are set on the financial resources available. The report provides an update of financial position against the finance operating plan and 23/24 budget.
Impact on local people, health inequalities and sustainability	Update of financial sustainability and performance of the system. Specific performance indicators address performance against the needs of those with protected characteristics (as defined by the Equalities Act) such as disability and that is included in the report.
Impact on finance, performance and quality	Delivery of the financial plan and meeting the control total and delivery of performance metrics and constitutional standards are mandated requirements.

Risks	The main risks flagged across the system are inflation, non-delivery of efficiencies, run rate and activity pressures and an income risk sitting with providers. The ICB risk rating remains at 20. A finance recovery plan is being developed across the system and will be submitted to regulators by the end of July.

1. Purpose of the Report

The purpose of the report is to update the ICB Board on the month 3 financial position and the risks associated with delivery of the ICS and ICB financial plan.

The ICB Board is recommended to note the contents of the report.

2. Month 3 Finance Overview

The month 3 year-to-date position across the NEL system is a overspend variance to plan of £41.8m. This is made up of a provider overspend variance of £33.5m with an ICB overspend variance of £8.3m.

The ICS as a whole is still forecasting to deliver a breakeven plan in line with the national reporting protocol, however the month 3 position would indicate a substantial risk to delivery. Whilst it is early in the year, and many efficiency and cost improvement (CIP) schemes have yet to bed down, the situation is of sufficient concern to warrant a formal financial recovery plan which is in development. More details on the ICB position and the recovery plan are set out later in the report.

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

Organisations	Year to date			Forecast Outturn		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
BHRUT	(1.8)	(10.9)	(9.2)	(0.2)	(0.2)	0.0
Barts Health	(6.7)	(26.1)	(19.5)	(27.8)	(27.8)	0.0
East London NHSFT	0.1	(1.1)	(1.3)	5.4	5.4	0.0
Homerton	(0.5)	(3.7)	(3.1)	0.2	0.2	0.0
NELFT	1.4	1.0	(0.4)	7.0	7.0	0.0
Total NEL Providers	**(7.4)**	**(40.8)**	**(33.5)**	**(15.3)**	**(15.3)**	**0.0**
NEL ICB	3.8	(4.5)	(8.3)	15.4	15.4	(0.0)
NEL System Total	**(3.6)**	**(45.3)**	**(41.8)**	**0.0**	**0.0**	**0.0**

All providers and the ICB are reporting year-to-date pressures at month 3, with the acute providers and the ICB showing the largest variation to plan.

The key pressures at a system level are as follows;

- **Inflation** – providers and the ICB have reported additional costs in relation to inflation being higher than planned levels.
- **Pay, including agency costs** – providers have reported pressures in relation to the agenda for change pay award. Additionally, agency usage is above the cap set by NHSE. The 23/24 cap is set at just under £141m. Reported year-to-date spend across providers is reported as £47m (or 33% of the total cap). The year-end submitted forecast on agency spend is £147m (£6m above the cap). However, the month 3 run rate on agency spend suggests that year-end spend could be in the region of £188m.
- **Impact of Industrial action** – BHRUT and Barts have reported year-to-date pressures as a result of the junior doctor strikes.
- **Efficiency and cost improvement plans** - the total system efficiency and cost improvement plan at month 3 is £51.8m. Of this £30m has been delivered, leaving a year-to-date under delivery against plan of £21.7m (£15.8m providers and £5.9m ICB). The ICB forecasts full delivery of efficiency at year-end with providers forecasting year-end under delivery of £17.6m. Delivery of the efficiency target and its impact on the recurrent underlying position remains a risk to the delivery of the financial position.

System capital shows a variance to allocation of £24.2m. £4.5m of this variance is in relation to the ICB and providers having plans in place to spend all of the available capital resource including the 5% extra allowed in planning. The relevant schemes are ready to be initiated when or if the funds become available. Additionally, NELFT are holding two additional leases on behalf of the ICB. The Trust is currently discussing the risk of this and options with London region. Within the ICB position there is a pressure of £1m relating to the capitalisation of lease costs.

2.1.1 – ICB Year-to-date and forecast position

The ICB year-to-date position is an adverse variance to plan of £8.3m, with a forecast break even position against the planned surplus of £15.4m.

The year-to-date position is driven by under delivery of efficiencies (£5.9m), primarily in CHC, prescribing and programme wide / corporate areas of spend. Additionally, there are reported run rate overspends of £3.7m in prescribing (price and activity pressures) and £1m in mental health (activity driven services, such as female Psychiatric Intensive Care Unit (PICU), section 117 and adult placements). These overspends are partly offset in the year-to-date position by an underspend in ring-fenced dental, ophthalmic and pharmacy (DOPs) spend.

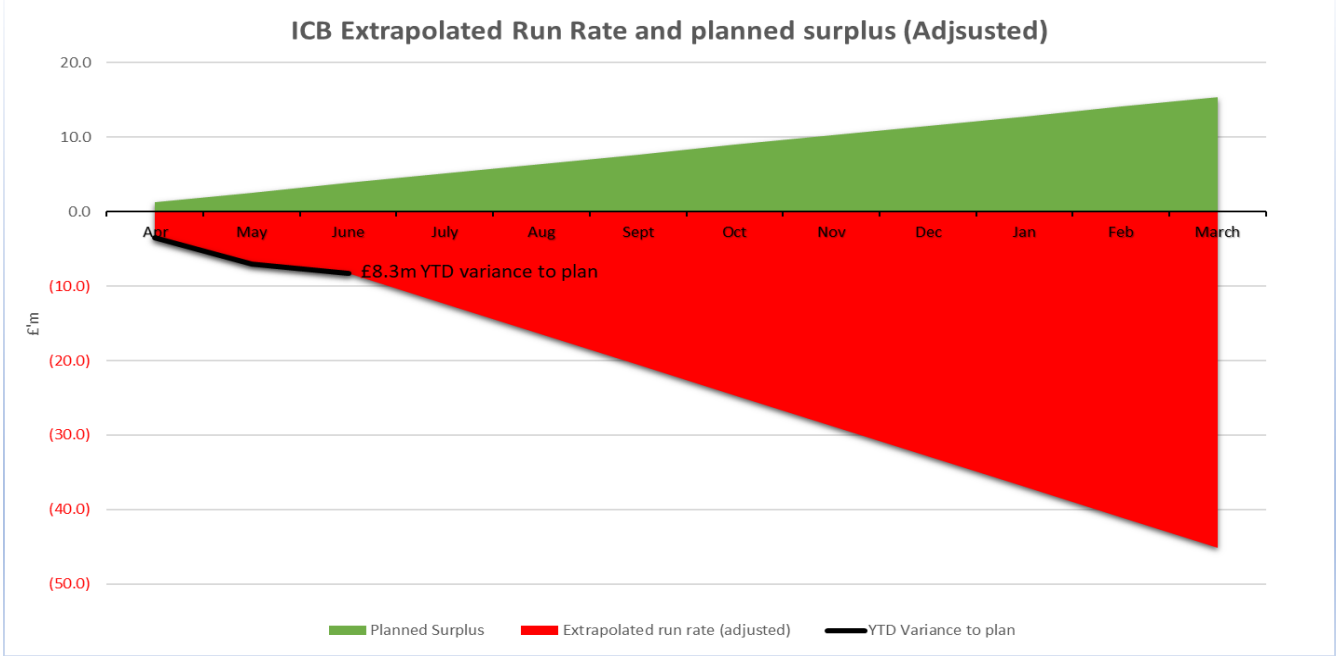
The detail by area of spend is shown in the table below:

	YTD Variance £m	FOT Variance £m
Current Variance to Plan	(8.3)	0.0
Acute	(0.1)	0.0
Mental Health	(1.0)	(0.0)
Community Health	(0.2)	(0.0)
Continuing Care	(2.6)	0.0
Primary Care - Co Commissioning	(0.0)	0.0
Primary Care - DOPs	1.6	0.0
Primary Care - Other	(4.3)	0.0
Running Costs	0.0	0.0
Programme Wide / Corporate	(2.8)	(0.0)
Other	1.1	(0.0)
Total Variance to Plan	**(8.3)**	**(0.0)**
Planned Surplus	3.8	15.4
(Deficit) / Surplus	**(4.5)**	**15.4**

The ICB is facing a run rate pressure of an adverse variance to plan of £8.3m. If the current run rate continues the trend suggests that the ICB variance to plan could be in the region of £45m at year-end.

In line with NHSE expectations and the operating plan the reported forecast surplus at year-end is £15.4m.

The run rate position and the operating plan forecast surplus are shown in the graph below.



The risks and associated mitigations are described further in the risk section of the report.

2.1.2 – System risks, mitigations and recovery plan

The total system risk at month 3 is just under £253m. Within this there is a high level of unmitigated risk. The potential impact of risk after mitigations is £150m. Without further mitigations being delivered this could result in a risk to delivery of the forecast position.

The risks are shown in the table below.

Organisation / System wide	Description of risk	Risk Level	Potential Impact before mitigations £m	Potential Impact after mitigations £m
System wide	Inflation risk	High	(44.2)	(38.5)
System wide	Excess cost risk - capacity, pressures, winter, run rate	High	(40.4)	(20.5)
System wide	Efficiency delivery risk	High	(113.3)	(89.6)
System wide	Income risk	High	(36.3)	(5.2)
System wide	Industrial Action	High	(18.7)	(18.7)
System wide	Mitigations to be developed	High	0.0	22.5
Total Risk			**(252.9)**	**(150.0)**

To address the potential impact of risk the ICS is currently working on a financial recovery plan which will be submitted to regulators at the end of July. The plan includes the following key steps:

- Quantification of the gap
- Re-phasing of the recurrent efficiency savings plan to deliver full year effect
- Identification of measures to close the in-year gap
- Stretch efficiency schemes
- Identify unpalatable measures to achieve the financial plan

Regular updates will be given on the financial recovery plan to future Finance, Performance and Investment Committees and ICB Board meetings.

3. Summary

The ICS has reported year-to-date pressures of £41.8m at month 3, with a forecast breakeven position at year-end. Without further mitigating actions, the level of risk identified is significant and may impact the delivery of the financial plan.

North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	Performance Report – April 2023 period
Author	Clive Walsh Interim Director of Performance
Presented by	Henry Black, Chief Finance and Performance Officer
Contact for further information	Clive Walsh Interim Director of Performance clive.walsh2@nhs.net
Executive summary	The attached set of slides describes the performance of the overall system across seven domains of performance in April 2023. For Urgent and Emergency Care (UEC) May 2023 data is available and this domain has been rated "Red" by the senior responsible officer (SRO). The total waiting list in planned care has risen over three months, as has the numbers of long waiting patients (>78 weeks wait). The total waiting list and number of long waiting patients are above trajectory. The impact of medical staffing industrial action continues to be seen, mainly in the area of planned care. The first industrial action by consultant medical staff is scheduled in July 2023. The number of patients waiting more than 62 days for cancer treatment has risen slightly but remains close to the trajectory. May 2023 was a challenged month for emergency care flow and this continued in June. The ICS is below its planned recovery trajectory to achieve 76% of patients seen within the 4-hour standard by March 2024. On 30 January 2023, a national UEC recovery plan was published, and the ICB was informed on 10 May 2023 that the system will be supported in Tier 1 (highest risk) for 2023/24. Several areas of support have been identified between the national team, NHSE and NEL ICB.
Action required	The Board is asked to note the report, and provide further feedback on improving the content and presentation, if required.
Previous reporting	Each of the performance domains has associated improvement activity and this is managed through system-wide Boards or collaboratives, for example, the Planned Care Board
Next steps / onward reporting	Reporting for the period March 2023 has previously been assessed by the NEL FPIC. The data has been updated for this ICB report.
Conflicts of interest	No known conflicts of interest
Strategic fit	This report aligns with the following ICS aims: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development

Impact on local people, health inequalities and sustainability	Improving access to healthcare and the speed of treatment is likely to benefit disadvantaged groups among the local residents. The ICS is participating with NHSE-London in building in the views of London residents on UEC services, and is awaiting the publication of an extensive piece of engagement in this area.
Impact on finance, performance and quality	The locality improvement plan, arising from the Care Quality Commission (CQC) inspection of the BHRUT Emergency Department and the adjacent Urgent Treatment Centre, will be monitored through the monthly UEC Programme Board. There have been more than 20 days of industrial action affecting patients (particularly for ambulance services and medical staffing), and the mitigating actions have increased costs, and resulted in extensive cancellation of planned care patients. There has been a London-wide and local discussion on evaluation of harm.
Risks	The risks and issues are described against the relevant performance domains. The top three risks in the CPFO risk log are impacted by the activity performance across the system

1.0 Purpose of the report

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

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

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

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

2.0 Key messages

2.1 The total waiting list in planned care has risen, along with the numbers of long waiting patients. The total waiting list is now above the trajectory level.

2.2 The UEC domain showed an improvement in UEC factors in April 2023, but fell back in May 2023 and June 2023 (not in the reporting period). The NE London system has been designated as Tier 1, requiring the highest of intervention and support from the national UEC team. There is an intention to marry up the processes for the Tier 1 status and the existing SOF4 process for BHRUT to streamline effort as far as possible.

2.3 The number of patients waiting more than 62 days for cancer treatment has risen, but remains slightly below trajectory. Barts and London Trust has moved to Tier 2 status, which involves a higher level of support from NHSE, with more frequent reporting.

3.0 Performance in April 2023

3.1 The attached set of slides describes the performance of the overall system across seven domains of performance in April 2023. For UEC May 2023 data is available. The detailed description and analysis for each of the domains is included in these slides.

3.2 Following the publication of the national UEC recovery plan, an evaluation process of relative performance has been undertaken by NHSE. This has led to the designation of NE London as a Tier 1 system, requiring the highest level of support and intervention. The focus of the national team is on improving flow and speed of treatment at BHRUT, although the whole ICS is designated as Tier 1 status. The measures of success for UEC in the 23/24 Operational Plan will be the 4-hour standard for patient treatment in Emergency Departments (ED) and the speed of transfer for patients from the ambulance service to ED care.

3.3 It is expected that NHSE will undertake a national assurance process in September 2023, reviewing 2022/23 Winter Plans and identifying good practice. NEL ICB has commissioned an external review of its winter planning, and this is expected to report in August 2023.

3.4 Several periods of industrial action have been held by ambulance staff (now resolved) and medical staff, through January to July 2023. In order to focus resources on urgent care services, planned care operations and appointments were significantly reduced. This represents a significant loss of volume, and has led to a delay in reducing waiting list size and waiting times. There will be a longer-term London-wide study into the harm resulting from these delays. There was a national requirement to treat all patients waiting longer than 78 weeks by 30 June 2023. The provisional number of long waiting patients at end June is 233, although this is not in the reporting period for this report to the Board.

4.0 Risks and mitigations

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

5.0 Conclusion

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

6.0 Attachments

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

7.0 Author

7.1 Clive Walsh, Interim Director of Performance
Each of the performance domains is reported by the subject expert.
Report drafted: 18 July 2023

Planned Care Recovery & Transformation – Apr 2023

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published April-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Planned Care	Total Waiting List (volume)	✗	199,382	207,588	▲	
	Waiting List >104 Weeks (volume)			3	▲	
	Waiting List >78 Weeks (volume)			295	▲	
	Waiting List >65 Weeks (volume)	✓	2,254	2,062	▲	
	Inpatient Elective Activity (% 19/20 BAU)	✗	85.91%	81.57%	▼	
	Consultant Led Outpatient Attendances (% 19/20 BAU)		89.16%	84.88%	▼	
	Consultant Led First Outpatient Attendances (% 19/20 BAU)		92.05%	79.98%	▼	
	Consultant Led Follow Up Outpatient Attendances without procedure (% 19/20 BAU)		92.64%	85.45%	▼	

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

Key Headlines

- The overall NEL RTT waiting list continued to increase in Apr-23 to 207,588 pathways (+3,464 pathways from the Mar-23 position). Increases at Barts Health (+2,230 pathways, across inpatient and outpatient waiting lists) and Homerton (+5,563 pathways, across inpatient and outpatient waiting lists). All three Trusts above the submitted operating plan for the month.
- The number of patients waiting 2 or more years (>104 weeks) for their planned care increased by +2 pathways in Apr-23, to a total of 3 pathways (2 pathways on the admitted waiting list and 1 pathway on the outpatient waiting list) at Barts Health.
- The number of patients waiting 18 months or more (>78 weeks) in NEL also increased in Apr-23 from the March position (+67 pathways), driven by Barts Health (+70 pathways from the Mar-23 position, to total of 294 pathways in April). Homerton reported 1 pathway >78ww for the month, down from 3 pathways in Mar-23.
- In line with the 23/24 Operating Plan ask to eliminate waits of 65 weeks or more (>65ww), the number of pathways in this cohort will be included in this report going forward. There were 2,062 >65ww in NEL in Apr-23, an increase of +168 pathways from the Mar-23 position. However, both Barts Health and BHRUT achieving against the submitted Operating Plan trajectory for the month.
- As set out in the 2023/24 Priorities and Operational Planning Guidance, systems are also expected to deliver in line with the national ambition to reduce outpatient follow-up appointments by 25% compared to 2019/20 by Mar-24, excluding appointments where a procedure takes place. The submitted trajectories do not expect to deliver a 25% reduction, however, the three NEL Trusts are working to achieve enhanced follow-up reduction from Q2. In Apr-23, total consultant led outpatient appointments were 85% of 2019/20 levels. Consultant led follow up appointments without a procedure were also 85% of 2019 levels (Barts Health 85%; BHRUT 77% and Homerton 101%).
- Total inpatient admitted activity completed at the three NEL Trusts in Apr-23 was 82% of 2019/20 levels (82% day case admissions and 81% ordinary admissions). All three NEL Trusts falling below plan for the month, with the exception of Homerton ordinary spells.

Workstream Issues and Risks

- Continued waiting list growth
- Impact of 2ww referral volumes
- The number of patients continuing to wait 2 years or more (>104 weeks) and 18 months or more (>78 weeks) at Barts Health post Jun-23, impacting ability to focus on other areas of the waiting list, including delivery of 0 >65ww by Mar-24
- Activity volumes and clock-stops not at required levels to significantly impact the waiting list
- Impact of ongoing Industrial Action on elective recovery, activity and the long waiting position – impact of cancellations, ongoing impact of displacement of activity (incl. impact on admin and scheduling staff), and to other activities that support waiting list management (e.g. triage, A&G/R, etc.,)
- Ability to meet and sustain reduction in follow-up activity balanced against the waiting list position and activity required to stop RTT clocks
- Potential impact and implications of national programme to increase 'Patient Choice' in relation to resource requirements to support delivery, existing capacity challenges and equity of waiting lists

Mitigating Actions and Next Steps

- Continued NEL and regional monitoring of the volume of patients waiting 2 years (>104ww), 18-months (>78 weeks) and >65ww
- >65ww modelling developed by Barts Health to understand capacity and booking rates required to meet 0 >65ww by Mar-24
- After action' review undertaken by Barts Health to understand drivers, learning and action required to support achievement of 0 >78w
- Ongoing NEL wide D&Q, PTL management and validation peer review. This now also includes review of access policies and specific support to Barts Health
- Ongoing Trust and site theatre productivity and utilisation programmes, overseen via the NEL Surgical Optimisation Group
- Ongoing use of collaborative capacity within NEL, outside of NEL and within the IS. NEL ICB collaborative capacity strategy for 23/24 agreed with Trust CEOs for action
- Targeted reduction to improve patient DNA rates and improve efficiencies
- Attendance at national 'Patient Choice' webinars to further understand requirements and the NEL baseline position against ICB and Acute asks
  The lifting of all referral restrictions in place across NEL underway to further support patient choice
-

Governance

- NEL Planned Care Recovery and Transformation Programme Bi-weekly assurance meetings held with NHSE region and Barts Health
- Trust productivity programmes overseen by the NEL Surgical Optimisation Group
- NEL risks, delivery and recovery escalated via the Planned Care Board

Outpatient Transformation – Apr 2023

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published April-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Outpatient Transformation	Moved or Discharged to PIFU (volume)	✓	2,815	2,959	▼	
	Moved or Discharged to PIFU (% OPA)	✓	1.40%	1.52%	▲	

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

Key Headlines

- As set out in the 2023/24 Priorities and Operational Planning Guidance, specialist advice (A&G/R and RAS) volumes and diversion rate are required at ICB level (based on all requests raised by NEL GPs). At the time of reporting validated ICB data for Apr-23 is not available - ICB level data will be reported from July onwards.
- In Apr-23, 2,959 patients were moved or discharged to PIFU, equating to 1.52% of all outpatient attendances. BHRUT achieving above plan for the month. Barts Health fell just below trajectory for the month with 777 pathways moved or discharged to PIFU, equating to 0.72% of all outpatient attendances. Despite, falling below plan Homerton continues to perform well with 4.6% of all outpatient attendances moved or discharged to PIFU.

Workstream Issues and Risks

- Volume of patients awaiting outpatient appointments and treatment
- System functionality and interoperability to support and expedite key initiatives and interventions e.g. PIFU
- Resource implications and job planning to support and expedite key initiatives and interventions e.g. GIRFT and A&G/R
- Elective Recovery Fund (ERF), incentivisation and funding structure for 23/24 (follow-up activity above 75% of 19/20 levels will not be funded in 23/24 and no national incentivisation for A&G/R)
- EROC (Elective Recovery Outpatient Data Collection) DQ
- Impact of ongoing Industrial Action on elective recovery, activity and the long waiting position – impact of cancellations, ongoing impact of displacement of activity (incl. impact on admin and scheduling staff), and to other activities that support waiting list management (e.g. triage, A&G/R, etc.,)

Mitigating Actions and Next Steps

- NEL modelling supported by NHSE region to understand opportunity for FUP reduction in line with national GIRFT guidance across specific pathways within T&O, General Surgery, Ophthalmology and Gynaecology
- 'Waiting Well NEL' website soft launch in May
- Work to provide patients and GPs with more meaningful information re waiting times via consistent and visible reporting of time to first outpatient appointment
- Ongoing roll-out of 'Advice and Refer' pilots across NEL (whereby all GP referrals receive advice and guidance prior to referral with the aim to reduce referrals, join up working, and 2-way support education)
- Plans to establish a clinically led outpatient transformation working group to help drive key programmes of work e.g. A&R, GIRFT, etc., to be taken forward
- Ongoing targeted reduction to improve patient DNA rates (e.g. the 'outpatient reminder service' in BHRUT).
- Outpatient follow-up reduction programme in place
- Roll-out of national GIRFT specialty outpatient guidance (clinically-led specialty outpatient guidance, developed for clinicians and operational teams) by individual Trust outpatient transformation programmes, supported at NEL level
- Use of the NEL 'sharing best practice group' to share learning and identify areas of focus e.g. Homerton PIFU case studies and impact assessment
- EROC (Elective Recovery Outpatient Data Collection) reconciliation and improved engagement with Trust BIU to ensure robust DQ
- Established work streams for MSK, Women's Health (gynae), ENT, Ophthalmology and Dermatology to develop alternate pathways and community capacity. The planned care board has recently reviewed the "MSK case for change" enabling the programme to move to the next stage of delivery
- All three NEL Trusts have signed-up to the national 'Further Faster' outpatient transformation pilots

Governance

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

Diagnostics – Apr 2023

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published April-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Diagnostics	Total Waiting List (volume)	N/A	N/A	52,926	▼	
	Waiting List >6 Weeks (volume)	N/A	N/A	8,895	▲	
	Performance (%)	N/A	N/A	83.19%	▼	

KEY

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

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

Key Headlines

- In Apr-23 there were 52,926 patients waiting for a diagnostics test in NEL (-3510 Pathways compared to Mar-23) position.
- The number of patients waiting longer than 6 weeks for a test saw an increase to 8,895 (+958 pathways compared to Mar-23) driven by increases across all three NEL Providers giving performance of 16.81% against the DM01 Target of 1%.
- NEL continues to report the highest volume of patients waiting an imaging investigation in London. The number of patients waiting over 6 weeks is greatest at Barts Health, mainly driven by waits for Non-Obstetric Ultrasound (NOUS), MRI, Audiology and CT.
- CT has the greatest increase in the no. of patients waiting over 6-weeks (920 patients, +491 Pathways more than Mar-23) followed by Sleep studies (143 patients, +132 Pathways more than Mar-23).
- The majority of patients waiting at HUH are waiting less than 6 weeks; with the challenged modalities being MRI, Non-Obstetric Ultrasound, Echocardiogram and Endoscopy. MRI downtime and increased Non-Obstetric Ultrasound demand are key drivers to overall position.
- The number of patients waiting over 6-weeks at BHRUT increased this month. CT, MRI and Peripheral Neurophysiology has the greatest backlog of all tests and the Trust has delivered Apr-23 performance of 6.08% which is >5% Target.
- Staff and patient related sickness, Industrial Action, are key drivers to NEL monthly DM01 position in Apr-23.
- Provisional Month end data for May-23 indicates NEL W/L at 51,739, backlog position at 8,053 and performance of 15.56% It is important to note the impact of Industrial action, Patient choice and clinic cancellations.

Workstream Issues and Risks

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

Mitigating Actions and Next Steps

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

Governance

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

Cancer – Apr 2023

SRO:	Femi Odewale	RAG	AMBER

	Metric	Latest Published April-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Cancer	Waiting List >62 Days (volume)	✓	646	636	▲	
	Faster Diagnosis Standard (%)	×	76.99%	71.10%	▼	

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

Workstream Issues and Risks

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

Governance

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

Key Headlines

- NEL cancer performance overall remains amongst the best in the country when compared to other systems in England and produced the comparable performance to the best performing London ICB's this month.
- In Apr-23, NEL delivered three of the nine cancer waiting time (CWT) constitutional standards for patients.
- 2 week-wait was non-compliant this month (85.37%) and no system across London achieved the Target. The 62 days urgent GP referral performance requires improvement. Remedial plans are in place and on track to improve albeit histopathology remains a key risk to delivery across NEL.
- BHRUT achieved the 2ww Breast Symptomatic standard in Apr-23. NEL Position was driven by fewer treatments owing to the impact of the industrial action coupled and workforce capacity at Barts Health. Plans are in place to improve this position in subsequent months.
- NEL failed to achieve the Faster Diagnosis Standard (FDS) in Apr-23 and no Providers achieved > 75% threshold. Mitigating actions are in place and performance improvement is expected going forward.
- NEL has made great progress in reducing the 62-day backlog in recent months. As at **18 Jun-23,** NEL had a total of (582 Patients) waiting >62 Days representing 6.9% of the total PTL (unvalidated).
- The backlog position is the lowest across London ICB's as at 18/06 and (+57 Patients) above trajectory

Mitigating Actions and Next Steps

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

Urgent and Emergency Care – May 2023

SRO:	Paul Gilluley	RAG	RED

	Metric	Latest Published May-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
UEC	Ambulance Handovers ≥ 60 Min (volume)	✗	National Req. ZERO	1,300	▲	
	12-hour Trolley waits (volume)	✗	National Req. ZERO	1,461	▲	
	Total A&E Attendances (volume)	✓	85,095	83,253	▲	
	A&E 4-Hour Performance All Type (%)	✗	68.81%	66.01%	▼	
	A&E 4-Hour Performance Type 1 (%)	✗	59.35%	57.13%	▼	

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

Key Headlines

- In May-23, 1,300 arrivals by ambulance at NEL emergency departments (EDs) took more than 1-hour to be transferred from London Ambulance Service care (up 368 on previous month; deterioration at BHRUT up 213 and Barts up 153). 83% of all handovers took place within 60 min (Barts 87%, BHRUT 69%, Homerton 100%), a worsened position on the previous month at Barts and BHRUT.
- 23% of arrivals by ambulance were handed over from London Ambulance service care within 15 min of arrival at ED (Barts 19%, BHRUT 9%, Homerton 70%), this was a worsened position at Barts and Homerton compared with the previous month.
- 54% of arrivals by ambulance were handed over within 30 mins of arrival at ED (Barts 58%, BHRUT 30%, Homerton 97%), down from 58% in Apr-23.
- In May-23, 66.01% of all patients were seen within 4-hours of arrival at ED, which did not deliver on the trajectory set at 68.81% as per the 2023-24 Operating Plan and down from 70% in Apr-23. A deterioration was seen at all Trusts. 57.13% of Type 1 patients (often considered the most Acute patients) were seen within 4-hours, down from 59.89% in Apr-23 and under achieving against the trajectory of 59.35% for the month.
- The national UEC recovery plan was published on 30 Jan 2022 and will form the basis of the 23/24 plan

Workstream Issues and Risks

- A combination of staffing shortages and increased acuity of patients attending EDs continue to present risk to the acute sites' ability to take handovers from Ambulance Crews. This was compounded by high numbers of MH patients spending protracted periods in EDs due to lack of capacity in MH Trusts.
- There are still overly high numbers of Medically Optimised patients occupying beds, which when combined with poor discharges, has a detrimental impact on flow and causes delays

Mitigating Actions and Next Steps

- Continued close working with LAS to review practices and SOPs across NEL acute sites for Ambulance Handovers
- Plans are in place for a concentrated review of both ED and LAS behaviours and processes at BHRUT sites in advance of commencing the 45min Handover initiative at the end of July
- Continued promotion of the REACH service to manage appropriateness of Ambulance Conveyances, where clinically sensible to do so – still only very low numbers of calls referred.
- Close working with Place Leads to examine progress of Virtual Ward capacity along with Community Beds and Domiciliary Care availability vs demand for discharges needing care packages.

Governance

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

Health Services in the Community – Mar/Apr 2023

SRO:	Charlotte Pomery and Jo Moss	RAG	AMBER

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

	Metric	Latest Published			
		Achievement	Trajectory	Actual	Change from prev. period
Health Services in the Community	Appointments in General Practice - Apr-23	✗	799,088	768,353	▼
	Learning disability registers and annual health checks delivered by GPs - Q4 22/23	✓	75.00%	88.00%	▲
	Personal Health Budgets - Q4 22/23	✗	4,311	4,195	▼
	2-hour Urgent Community Response (UCR) care contacts - Count of 2-hour UCR first care contacts delivered within reporting quarter - Q4 22/23	✗	1,684	1,521	▲
	Community services waiting list-Number of patients waiting at a point in time aggregated for a) in scope CYP and b) in scope Adult services - Q4 22/23	✗	31,383	31,712	▼
	Number of CYP (0-17 years) on community waiting lists - Q4 22/23	✗	11,170	12,711	▼
	Number of Adults (18+ years) on community waiting lists - Q4 22/23	✓	20,213	19,001	▼

Key Headlines

Primary Care

- The actual number of booked appointments was 96% of trajectory during April. During April 44% of appointments were seen on the same day and 77% were within 7 days. 65% were face-to-face and 33% over the phone. 56% of these appointments were with a GP and 42% with another member of practice staff like a nurse. This is in line with the London average. We are viewing access to general practice alongside a range of measures that capture both the technical as well as the perceived quality elements of good access. We are developing a set of principles to support place based teams to streamline patient access to the most appropriate type of appointment and advice with clear signposting for health care professionals and residents to ensure they are directed to the full range of services available.
- Local workstreams are in being put in place to implement The Primary Care Recovery Plan. GP Capacity and Improvement payments will help practices to improve patient experience of contacting the practice, manage demand and capacity and ensure accurate recording in appointment books.
- Plans to implement integrated same day access, under the Fuller Programme are being put in place.

Learning disability

- NHS North East London exceeded the target of 75% of people on the LD register having their Annual Health Check in 2022/23, as it has in previous years. There is an established method of working across the programme and at PLACE to ensure take up remains high, including reconciliation by the Community Learning Disability Teams, direct liaison with individual surgeries where support is required, and wider training for GP surgeries, which we will continue to offer this in 2023/24.
- Oversight of delivery will continue to be undertaken by the Learning Disabilities and Autism Transformation Board and the Mental Health, Learning Disabilities and Autism Strategic Board.

Personal Health Budgets

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

2 hour UCR

- UCR – Based on the published data: At NEL Level the UCR 2 hours standard has not been achieved (67% against 70% target). ELFT (No data) and NELFT (74%) and Homerton (94%) against 70% target. Based on the local data from providers. Published March referral data does not include ELFT. This is either due to ELFT not submitted the data for March or the submitted data has not been picked up due to issues in latest CSDS version. This has been raised with ELFT team.

Community Waiting List

- NEL ICB ranks 15th out of 42 ICBs; an improvement from 12th position in February with 19,001 adult referrals above the average of 17,294. NEL ICB remains 4th out of all the ICBs, with 12,7111 child referrals above the average of 5,549. The number of adult referrals across NEL in March 2023 was 19,001 a 2% decrease compared to February. This is comprised of; 30% ELFT, 27% Barts, 25% NELFT and 17% Homerton. The number of child referrals in March 2023 was 12,711 a 3% increase compared to February. This is comprised of 49% NELFT, 22% ELFT, 17% Homerton and 12% Barts. Overall for NEL there has been an increase in the number of referrals for children, with significant increases in Barts referrals for children's services. ELFT saw an 8% decrease in referrals to children's services. Homerton also saw increases in referrals to children's services but a decrease for referrals for adults services.

Workstream Issues and Risks

Primary Care

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

Learning disability

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

2 hour UCR

- UCR - NEL consistently meeting 2hr UCR Target but There is a drop for March due to data entry from ELFT to 67%. NEL is working on pull pilot to increase case numbers from 111/999 but it needs to be led clinically with a polit across one borough before roll out across region. NEL is meeting 9 clinical matrix standards but more work needs to be done to check consistency across providers.
- Falls prevention data has been given to all ICBs to begin to review and probe in more detail how they can prevent admissions from care homes. This needs to be a focused area for Enhanced health and care homes delivery by Q3. No target yet.

Community Waiting List

- For child referrals for March, 692 referrals were waiting over 52 weeks a 4% decrease compared to February. Of that cohort, 643 referrals were waiting between 52-104 weeks; 40% of this cohort were for ELFT Community paediatric service and 23% for Homerton audiology service this was previously zero. Of the 49 referrals waiting over 104 weeks; NELFT community paediatric service (18), ELFT community paediatric service (10), ELFT Physiotherapy (8), NELFT Physiotherapy (7), NELFT Occupational therapy (4) and ELFT speech and language (2).
- There were 4,500 child referrals waiting between 18-52 weeks a 25% increase compared to February, and 28% were for both NELFT community paediatric service and ELFT community paediatric service. Although there has been an increase in the number of referrals for 18-52 weeks, the number of referrals for 52-104 weeks has decreased by 1% and referrals waiting over 104 weeks decreased by 30%.
- Waiting List – Increases are due to Workforce recruitment & availability, increased demand and referrals. Data continues to be heavily caveated – it is provider level, but waits still reflect on NEL. Data Cleansing needs to continue by providers.

Mitigating Actions and Next Steps

Primary Care

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

Learning disability

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

2 hour UCR

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

Community Waiting List

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

Governance

Primary Care

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

Learning disability

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

2 **hour UCR and Community Waiting List**

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

Mental Health – April 2023

SRO:	Dan Burningham	RAG	AMBER

	Metric	Latest Published				
		Apr-23	*Trajectory*	*Actual*	Change from prev. Month	6 Month Trend
Mental Health	IAPT Access (Volume)	✗	*4,190*	*3,810*	▼	
	Dementia Diagnosis (Rate)	✗	*66.70%*	*59.52%*	▲	
	SMI Physical Health Checks (Performance)	✓	*60.00%*	*64.79%*	▲	
	Perinatal (Rate)	✗	*7.87%*	*7.50%*	▲	
	CYP Access (Volume)	✗	*22,608*	*22,385*	▲	
	Early Intervention in Psychosis (EIP)	✓	*60.00%*	*76.47%*	▲	
	CYP Eating Disorders Urgent Referral (Performance)	✓	*95.00%*	*98.21%*	▲	
	CYP Eating Disorders Routine Referral (Performance)	✗	*95.00%*	*94.07%*	▲	
	SMI Community Access (Volume)	✓	*20,940*	*21,142*	▼	

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

Key Headlines

- Almost all measures of service performance have improved since 2022/23. However, some plans for 2023/24 have not been achieved, due to the substantial rate of improvement required and dips in April reporting.
- Services of note are; Talking Therapies, Children and Young People's (CYP) mental health access, Perinatal mental health support to women, Dementia diagnosis, Physical Health Checks for people with Serious Mental Illness (SMI), and Community Access for people with Serious Mental Illness.
- The NEL position compared with other London systems is mixed. CYP access and SMI health checks are performing well against the London position, however Dementia diagnosis performance is challenged compared to other London regions.

Workstream Issues and Risks

- While a number of measures of service improvement achieved their year-end performance targets in 2022/23 and are showing sustained improvement, there are steep trajectories in place for a number of measures in 2023/24.

Mitigating Actions and Next Steps

- While there are no recovery plans in place for 2023/24, there is ongoing work supported by clinically led NEL wide groups.
- Ongoing work includes changes to service models to improve effectiveness and productivity, and address health and social inequalities, as well as aligning investment and workforce planning. Examples include:
- Talking Therapies access – a focus on recruitment and increasing referral rates, and increasing uptake of group therapy
- CYP access – increasing primary care access, improving digital access by service users, and increase access in schools via Mental Health support teams
- Perinatal – increasing capacity through recruitment

Governance

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

North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	Governance Handbook Amendments
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery, Chief Participation and Place Officer
Contact for further information	annemarie.keliris@nhs.net

Executive summary	At its last meeting, the Board agreed the updated Governance Handbook, which sets out the governance arrangements for the organisation, including terms of reference (ToRs) and governance policies.
	
	Following this meeting there have been a number of further governance developments which cover the following areas:
	• Barking and Dagenham Committees in Common and revised ICB sub-committee terms of reference.
	• Establishment of joint committees of:
	  ○ mental health, learning disabilities and autism provider collaborative
	  ○ acute provider collaborative
	• Primary Care Contracts sub-committee revised terms of reference.
	• Updates to the scheme of reservation and delegation (SoRD).
	• Board and committee effectiveness themes.
	
	Further details on each of these developments are contained within the report below.

Action required	To approve: • The revised Barking and Dagenham ICB sub-committee terms of reference – appendix A • The MHLDA joint committee terms of reference – appendix B • The Acute Provider Collaborative Joint Committee terms of reference – appendix C • The revised primary care contract sub-committee terms of reference - appendix D • Scheme of reservation and delegation – appendix E • The updated Governance Handbook here.

	To note, consider and agree • the key themes of the board and committee effectiveness surveys – appendix F • consider and agree recommendations.
Previous reporting	ICB Board and Sub-committees.
Next steps/onward reporting	The Governance Handbook will then be further reviewed on an annual basis.
Conflicts of interest	Not applicable
Strategic fit	Links to overall design and governance of the ICB and integrated care system as established on 1 July 2022 and to support all four core objectives: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The new inclusive governance is designed to support the new organisation and system to make improvements to access, experience and outcomes for local people - with an overall focus on tackling health inequalities.
Impact on finance, performance and quality	There are no immediate financial implications.
Risks	There are no immediate risks identified.

1.0 Background

1.1 At its last meeting, the Board agreed the updated Governance Handbook, which sets out the governance arrangements for the organisation, including terms of reference (ToRs) and governance policies.

1.2 Following this meeting there have been further governance developments which cover the following areas.

2.0 Barking and Dagenham Committees in Common and revised sub-committee terms of reference

2.1 At the last meeting, the Board supported the committees in common of the ICB place sub-committee with the London Borough of Barking and Dagenham Health and Wellbeing Board. The ICB sub-committee terms of reference have been revised to reflect the new approach and these were endorsed by the ICB sub-committee at its first committees in common on 26 June 2023.

3.0 Provider Collaborative Joint Committees

3.1 Over recent months the ICB has been working provider colleagues and legal advisors to develop joint committee arrangements for the mental health, learning disabilities and autism (MHLDA) collaborative and the acute provider collaborative (APC). These arrangements rely on new legislative flexibilities introduced by the Health and Care Act 2022, enabling NHS bodies to work together and take decisions jointly, and to establish joint committees. The MHLDA Collaborative has also continued to develop its arrangements through NHS England's Provider Collaborative innovators' scheme.

3.2 The proposed terms of reference (ToR) for each new collaborative joint committee have been approved by the relevant Trust and Foundation Trust Boards, with the exception of Homerton Healthcare NHS Foundation Trust Board which is meeting on the same day as the ICB Board to consider the establishment and terms of reference of the APC Joint Committee. A verbal update will be given to the ICB Board, regarding the Homerton Healthcare NHS Foundation Trust Board decision.

3.3 Alongside establishment of the two joint committees, the current MHLDA collaborative and APC sub-committees of the ICB's Population Health & Integration (PH&I) committee will be disestablished. The joint committees will, however, continue to have a reporting line into the PH&I committee.

4.0 Primary Care Contracts Sub-Committee

4.1 At the last meeting, the Board noted that the delegation agreement with NHS England for dentistry, optometry and pharmacy services, which was included in the updated governance handbook following approval at the March Board meeting. At the meeting of the primary care contracts sub-committee held on 24 July the sub-committee endorsed the revised ToR to include commissioning and contracting functions as part of the implementation of the delegation agreement.

5.0 Scheme of Reservation and Delegation (SoRD)

5.1 The SoRD has been updated to reflect the following changes:

- Approval of ICB operational policies at the executive management team;
- Implementation of recent statutory guidance on executive lead roles.

5.2 A further update of the SoRD will be presented to the next meeting to include primary care contracting and commissioning functions.

6.0 Board and Committee effectiveness

6.1 As reported at the last meeting, members of the board and committees were asked through a survey to share their views on the effectiveness of their board/committees, reflecting on what went well and what could be improved. This is to inform future development of the board/committee and a summary of the results are included in the annual report. Given the ICB was established part way through the financial year, with nine months of board/committee operations from July to year end, these results are a more limited snapshot than usual, but still provide useful feedback to consider in terms of what to build on, change and develop for the new financial year. The key themes from these surveys are attached at appendix F – a common theme across both the boards and committees is ensuring discussions and decisions are transparent and understood across the ICB governance structure and the governance team are exploring options to address this theme.

6.2 Members are asked to consider and agree recommendations to develop and strengthen governance for the second year of the ICB.

7.0 Recommendations

7.1 The Board are asked to approve:

- The revised Barking and Dagenham ICB sub-committee terms of reference – appendix A
- The MHLDA joint committee terms of reference – appendix B
- The Acute Provider Collaborative joint committee terms of reference – appendix C
- The revised primary care contract sub-committee terms of reference - appendix D
- SoRD – appendix E.
- The updated Governance Handbook here.

7.2 The Board are asked to note, consider and agree

- the key themes of the board and committee effectiveness surveys – appendix F
- Propose any recommendations to strengthen governance for the second year of the ICB.

North East London
Integrated Care Board

BARKING & DAGENHAM

SUB-COMMITTEE OF THE NORTH EAST LONDON ICB

DRAFT TERMS OF REFERENCE

Contents

Barking and Dagenham Place Based Governance

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

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

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

Arrangements from 26 June 2023

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

    Governance structures

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

    (b) The B&D Partnership Board is disestablished. However, the vision, mission and values explained in the former B&D Partnership Board's terms of

reference, and as far as possible its role and responsibilities, will be fulfilled through the aligned meetings of the committees-in-common. Those aligned meetings will be the primary governance mechanism for collaborating on strategic policy matters and overseeing joint programmes of work relating to health and social care at Place.

(c) Other ICS partners[1] may take decisions relating to statutory functions at meetings of the aligned structures through individuals having delegated authority from their organisation, as reflected in the organisation's own internal governance (e.g. schemes of delegation).

Membership

(d) To facilitate its broader work, the Health and Wellbeing Board's membership will be expanded to include the following additional non-voting members:

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

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

(f) The Place ICB Sub-committee's membership will remain as set out in its terms of reference, except that the Chair of the Health and Wellbeing Board will also be the sole chair of the Place ICB Sub-committee. A deputy chair will be appointed from the membership.

Participation

(g) Any member or standing participant of the Health and Wellbeing Board, who is not a member of the Place ICB Sub-committee, will have a standing invitation

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

to attend meetings of the Place ICB Sub-committee when it meets together with the Health and Wellbeing Board.

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

Administration of meetings

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

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

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

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

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

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

(m) All those who are members or participating in a meeting of the Health and Wellbeing Board or Place ICB Sub-committee shall continue to follow the Seven Principles of Public Life (also commonly referred to as the Nolan Principles), which are: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

Development of aligned terms of reference

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

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

Review

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

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

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

North East London
Integrated Care Board

Terms of reference for the Barking & Dagenham Sub-Committee of the North East London Integrated Care Board

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

Framework, which may be updated by the Board taking into account the views of the PH&I Committee.

9. The Delegated Functions shall be exercised with particular regard to the Place objectives and priorities, described in the plan for Place ('**the PBP Plan'**), which has been agreed with the PH&I Committee. A summary of the PBP's priorities and objectives can be found here.

10. In addition, the Place ICB Sub-Committee will support the wider ICB to achieve its agreed deliverables, and to achieve the aims and the ambitions of:

    (a) The Joint Forward Plan;

    (b) The Joint Capital Resource Use Plan;

    (c) The Integrated Care Strategy prepared by the NEL Integrated Care Partnership;

    (d) The Health and Wellbeing Board's joint local health and wellbeing strategy with the Health and Wellbeing Board's needs assessment for the area;

    (e) The Place Mutual Accountability Framework and the NHS North East London Financial Strategy and developing ICS Financial Framework;

    (f) The PBP Plan.

11. The Place ICB Sub-Committee will also prioritise delivery against the strategic priorities of the North East London Integrated Care System (see here) and its design and operating principles set out here.

12. In supporting the ICB to discharge its statutory functions and deliver the strategic priorities of the ICS at Place, the Place ICB Sub-Committee will, in turn, be supporting the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to:

    (a) Improve outcomes in population health and healthcare;

    (b) Tackle inequalities in outcomes, experience and access;

    (c) Enhance productivity and value for money;

    (d) Help the NHS support broader social and economic development.

13. The Place ICB Sub-Committee is a key component of the ICS, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.

Key duties relating to the exercise of the Delegated Functions

14. When exercising any Delegated Functions, the Place ICB Sub-Committee will ensure that it acts in accordance with, and that its decisions are informed by, the guidance, policies and procedures of the ICB or which apply to the ICB.

15. The Sub-Committee must have particular regard to the statutory obligations that the ICB is subject to, including, but not limited to, the statutory duties set out in the 2006 Act and listed in the Constitution. In particular, the Place ICB Sub-Committee will also have due regard to the public sector equality duty under section 149 of the Equality Act 2010.

Collaborative working

16. In exercising its responsibilities, the Place ICB Sub-Committee may work with other Place ICB Sub-Committees, provider collaboratives, joint committees, committees, or sub-committees which have been established by the ICB or wider partners of the ICS. This may include, where appropriate, aligning meetings or establishing joint working groups.

Collaboratives

17. In particular, the Place ICB Sub-Committee will, as appropriate, work with the following provider collaborative governance structures within the area of the ICS:

    (a) The North East London Mental Health, Learning Disability & Autism Collaborative;

    (b) The Combined Primary Care Provider Collaborative;

    (c) The North East London Acute Provider Collaborative;

    (d) The North East London Community Collaborative;

    (e) The evolving Voluntary, Community and Social Enterprise Sector Alliance/Collaborative.

18. Some members of the Place ICB Sub-Committee may simultaneously be members of the above collaborative structures, to further support collaboration across the system.

Health & Wellbeing Board and Safeguarding

19. The Place ICB Sub-Committee will also work in close partnership with:

    (a) The Health and Wellbeing Board and shall ensure that plans agreed by the Place ICB Sub-Committee are appropriately aligned with, and have regard to, the joint local health and wellbeing strategy and the assessment of needs, together with the NEL Integrated Care Strategy as applies to Place; and

    (b) The Safeguarding Adults Board for the Place established by the local authority under section 43 of the Care Act 2014; and

    (c) The Safeguarding Children's Partnership established by the local authority, ICB and Chief Officer of Police, under section 16E of the Children Act 2004.

Establishing working groups

20. The Place ICB Sub-Committee does not have the authority to delegate any functions delegated to it by the ICB. However, the Place ICB Sub-Committee

	may establish working groups or task and finish groups. These do not have any decision-making powers but may inform the work of the Place ICB Sub-Committee and the PBP. Such groups must operate under the ICB's procedures and policies and have due regard to the statutory duties which apply to the ICB.
Chairing and executive lead arrangements	21. The Place ICB Sub-Committee will be chaired by the Chair of the Health and Wellbeing Board who is appointed on account of their specific knowledge, skills and experience making them suitable to chair the Sub-Committee.. 22. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference. 23. A deputy Chair will be appointed from the membership. 24. If the Chair or deputy Chair has a conflict of interest then the Sub-Committee will select another member of the Sub-Committee to be responsible for deciding the appropriate course of action. 25. The Acting Chief Executive of LBBD will be the Place Partnership Lead.
Membership	26. The Place ICB Sub-Committee members will be appointed by the Board in accordance with the ICB Constitution and the Chair of the ICB will approve the membership of the Sub-Committee. 27. The Place ICB Sub-Committee has a broad membership, including those from organisations other than the ICB. This is permitted by the ICB's Constitution and amendments made to the 2006 Act by the Health and Care Act 2022. 28. The membership of the Place ICB Sub-Committee includes members drawn from the following partner organisations which operate at Place: (a) The ICB (b) BHRUT (c) NELFT (d) LBBD (e) Barking & Dagenham GP Federation (f) PCNs (g) BD Collective (h) Healthwatch 29. There will be a total of 14 members of the Place ICB Sub-Committee, as follows: *ICB*

(a) Place Director for Barking & Dagenham

(b) Clinical Care Director for Barking & Dagenham

(c) Director of Finance or their nominated representative

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

LBBD

(e) Cabinet Member for Adult Social Care and Health Integration (**Chair**)

(f) Chief Executive (**Place Partnership Lead**)

(g) Strategic Director Children and Adults

(h) Director of Public Health

NHS Trusts/Foundation Trusts

(i) Executive Director of Partnerships (NELFT)

(j) Director of Strategy & Partnerships (BHRUT)

Primary Care

(k) Place Based Partnership Primary Care Development Clinical Lead

(l) Primary Care Network Director (nominated by the PCN clinical directors)

Others

(m) Chair, Healthwatch

(n) Chair, BD Collective

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

31. When determining the membership of the Sub-Committee, active consideration will be made to diversity and equality.

Participants

32. Only members of the Sub-Committee have the right to attend Sub-Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Sub-Committee.

33. The Chair may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion on particular matters.

Resource and financial management	34. The ICB has made arrangements to support the Place ICB Sub-Committee in its exercise of the Delegated Functions. Financial responsibilities of the Place ICB Sub-Committee are contained in the list of Delegated Functions in Annex 1, and further information about resource allocation within the ICB is contained in the ICB's Standing Financial Instructions and associated policies and procedures, which includes the NHS North East London Financial Strategy and developing ICS Financial Framework. 35. The Chair will be invited to attend the Finance Performance and Investment Committee where the Committee is considering any issue relating to the resources allocated in relation to the Delegated Functions.
Meetings, Quoracy and Decisions	36. The Place ICB Sub-Committee will operate in accordance with the ICB's governance framework, as set out in its Constitution and Governance Handbook and wider ICB policies and procedures, except as otherwise provided below: *Scheduling meetings* 37. The Place ICB Sub-Committee will aim to meet on a bi-monthly basis and, as a minimum, shall meet on four occasions each year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair. 38. The Place ICB Sub-Committee will usually hold its meetings together with the Health and Wellbeing Board, as part of an aligned meeting of the PBP. Although the Place ICB Sub-Committee may meet on its own at the discretion of its Chair, it is expected that such circumstances would be rare. 39. The Board, Chair of the ICB or Chief Executive may ask the Sub-Committee to convene further meetings to discuss particular issues on which they want the Sub-Committee's advice. *Quoracy* 40. The quoracy for the Place ICB Sub-Committee will be six and must include the following of which one must be a care or clinical professional: (a) Two of the members from the ICB; (b) Two of the members from the local authority; (c) One of the members from an NHS Trust or Foundation Trust; (d) One primary care member. 41. If any member of the Sub-Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. 42. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. *Voting*

43. Decisions will be taken in accordance with the Standing Orders. The Sub-Committee will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the Sub-Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. The result of the vote will be recorded in the minutes.

44. Where there is a split vote, with no clear majority, the Chair will have a casting vote.

Papers and notice

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

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

Virtual attendance

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

Admission of the public

48. Meetings at which public functions of the ICB are exercised will usually be open to the public, unless the Chair determines, at their discretion, that it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for some other good reason.

49. The Chair shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business shall be conducted without interruption and disruption.

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

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

52. There shall be a section on the agenda for public questions to the committee, which shall be in line with the ICB's agreed procedure as set out on our website here.

Recordings of meetings

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

Confidential information

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

Meeting Minutes

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

56. Where it would promote efficient administration, meeting minutes and/or action logs may be combined with those of the Health and Wellbeing Board.

Legal or professional advice

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

Governance support

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

Conflicts of Interest

59. Conflicts of interest will be managed in accordance with the policies and procedures of the ICB and those contained in the Handbook and shall be consistent with the statutory duties contained in the National Health Service Act 2006 and any statutory guidance issued by NHS England.

Behaviours and Conduct

60. Members will be expected to behave and conduct business in accordance with:

    (a) The ICB's policies and procedures including its Constitution, Standing Orders and Standards of Business Conduct Policy which includes the Code of Conduct which sets out the expected behaviours that all members of the Board and its committees will uphold whilst undertaking ICB business.

(b) The NHS Constitution;

(c) The Nolan Principles.

61. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.

Disputes

62. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the Place ICB Sub-Committee in its capacity as a decision-making body within the ICB's governance structure, including uncertainty about whether the matter relates to:

(a) a matter for wider determination within the ICS; or

(b) determination by another placed-based committee of the ICB or other forum, such as a provider collaborative,

then the matter will be referred to the Director who is responsible for governance within the ICB for consideration about where the matter should be determined.

Referral to the PH&I Committee

63. Where any decision before the Place ICB Sub-Committee is 'novel, contentious or repercussive' across the ICB area and/or is a decision which would have an impact across the ICB area, then the Place ICB Sub-Committee shall give due consideration to whether the decision should be referred to the PH&I Committee.

64. With regard to determining whether a decision falling within the paragraph above shall be referred to the PH&I Committee for consideration then the following applies:

(a) The Chair of the Place ICB Sub-Committee, at their discretion, may determine that such a referral should be made.

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

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

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

(a) The PH&I Committee, or its Chair and Deputy Chair (acting together), may determine that any decision falling with paragraph 63 should be referred to the PH&I Committee for determination; or

	(b) The Board of the ICB, or its Chair and the Chief Executive (acting together), may require a decision related to any of the ICB's delegated functions to be referred to the Board.
Accountability and Reporting	67. The Place ICB Sub-Committee shall be directly accountable to the PH&I Committee of the ICB, and ultimately the Board of the ICB. 68. The Place ICB Sub-Committee will report to: (a) **The PH&I Committee** following each meeting of the Place ICB Sub-Committee. A copy of the meeting minutes along with a summary report shall be shared with the Committee for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval. And will report matters of relevance to the following: (b) **Finance, Performance and Investment Committee.** Such formal reporting into the ICB's Finance, Performance and Investment Committee will be on an exception basis. Other reporting will take place via Finance and via NEL wide financial management reports. (c) **Quality, Safety and Improvement ('QSI') Committee.** Reports will be made to the QSI Committee in respect of matters which are relevant to that Committee and in relation to the exercise of the quality functions set out here. 69. In the event that the Chair of the ICB, its Chief Executive, the Board of the ICB or the PH&I Committee requests information from the Place ICB Sub-Committee, the Place ICB Sub-Committee will ensure that it responds promptly to such a request. *Shared learning and raising concerns* 70. Where the Place ICB Sub-Committee considers an issue, or its learning from or experience of a matter, to be of importance or value to the North East London health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the ICB for onward referral to the PH&I Committee, the Chair or Chief Executive of the ICB, the Board, the Integrated Care Partnership or to one or more of ICB's committees or subcommittees, as appropriate.
Review	71. The Place ICB Sub-Committee will review its effectiveness at least annually. 72. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Version: 3.0

Date of review: 1 April 2024

Annex 1 - ICB Delegated Functions

Commissioning functions

In addition to the specific activities set out in this Annex 1 below, the Place ICB Sub-Committee will have delegated responsibility for exercising the functions described in the Place Mutual Accountability Framework at Place. These functions are referred to below as '**the Place Commissioning Functions'**.

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

Where Place Commissioning Functions relate to a particular service they must be exercised in line with the ICB's relevant commissioning policy for that service.

Health and care needs planning

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

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

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

3. Overseeing the development of service specification standards needed in connection with the exercise of the Place Commissioning Functions and in line with relevant ICB policy.

4. Working with the Health and Wellbeing Board on behalf of the ICB, to develop the PBP Plan including the Place objectives and priorities and a Place outcomes framework.

    The PBP Plan shall be developed by drawing on data and intelligence, and in coproduction with service users and residents of Barking & Dagenham. It is aimed at ensuring delivery of the Joint Forward Plan, the Integrated Care Strategy, the Health and Wellbeing Board's joint local health and wellbeing strategy and associated needs assessment, and other system plans.

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

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

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

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

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

Market management, planning and delivery

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

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

2. Approving commissioning policies connected with the exercise of the Place Commissioning Functions, in line with ICB policy.

3. Approving demographic, service use and workforce modelling and planning, where these relate to the Place Commissioning Functions.

Finance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality

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

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

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

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

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

    - Ensure the delivery of quality objectives by providers and partners within Place, including ICS programmes that relate to the place portfolio.

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

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

Primary Care

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

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

Communication and engagement with stakeholders

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

1. Overseeing and approving any stakeholder involvement exercises proposed specifically in Place, consistent with the ICB's statutory duties in this context and the ICB's relevant policies and procedures. Such stakeholder engagement shall include political engagement, clinical and professional engagement, strategic partnership management and public and community engagement.

2. Overseeing the development and delivery of patient and public involvement activities, as part of any service change process occurring specifically at Place.

Population health management

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

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

Emergency planning and resilience

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

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

The North East London Mental Health, Learning Disability & Autism Collaborative Joint Committee

TERMS OF REFERENCE
DRAFT

Introduction

1. The NHS North East London Integrated Care Board ('**ICB**'), East London NHS Foundation Trust ('**ELFT**') and North East London NHS Foundation Trust ('**NELFT**'), who are partners of the North East London Integrated Care System ('**ICS**'), have come together to form the North East London Mental Health, Learning Disability & Autism Collaborative Joint Committee ('the **Collaborative Joint Committee**').

2. For the purpose of these terms of reference, the ICB, ELFT and NELFT shall be known as the '**NHS Partner Organisations**.'

3. The Collaborative Joint Committee, whose governance arrangements are described in these terms of reference, is the collective governance vehicle for joint decision-making by the NHS Partner Organisations, in relation to Mental Health, Learning Disability & Autism ('**MHLDA**') services.

4. It 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, access and experience; improve resilience (e.g. by mutual aid); and ensure that specialisation and consolidation can occur where this will provide better outcomes and value.

Status

5. Section 65Z5 of the National Health Service Act 2006 (as amended) (the '**2006 Act'**) permits Integrated Care Boards and NHS foundation trusts to exercise their functions jointly with each other, subject to:

   (a) Regulations made by secondary legislation, which may constrain that joint exercise of functions, limit the power in relation to certain functions of one or more of those organisations, or impose conditions on the exercise of that power.

   (b) The expectations of statutory guidance about the exercise of this power, which is published by NHS England under section 65Z7 and which the NHS Partner Organisations must have regard to.[1]

6. Section 65Z6 permits the organisations to arrange for the functions which are exercisable jointly to be exercised by a joint committee and, if they wish, for one or more of the organisations or the joint committee itself to establish and maintain a pooled fund.

[1] Current statutory guidance: Arrangements for delegation and joint exercise of statutory functions (September 2022).

7. Arrangements made under section 65Z5 and section 65Z6 may be made on such terms as may be agreed between the organisations, including terms as to payment.

8. An NHS foundation trust is also permitted by section 47A of the 2006 Act to enter into arrangements for the carrying out, on such terms as it considers appropriate, of any of its functions jointly with any other person.

9. Integrated Care Boards also have powers under section 12ZA of the 2006 Act, in relation to arrangements they have made with service providers, which includes a power to confer discretions on those services providers.

10. By virtue of the powers described above, and in accordance with each of their constitutional and governance arrangements, the NHS Partner Organisations have formally established the Collaborative Joint Committee.

Aims

11. Our aim is to work together to improve outcomes, quality, value and equity for people with, or at risk of, mental health problems and/or learning disability and autism in North East London. We will:

    (a) Ensure that our work to plan and improve in MHLDA is done with the best expertise and evidence and in full collaboration between service users and carers, communities, expert clinicians, care professionals, voluntary sector and academic partners

    (b) Refresh and revitalise how we plan, deliver and hold ourselves accountable for mental health outcomes, quality, value and equity in our borough partnerships, and in particular involving service users, carers and citizens much more squarely in both the design of new programmes and in holding us to account for delivery

    (c) Refocus our effort on driving down inequalities across our communities in North East London. This means focusing more on underlying causes and targeted support to ensure services are based on the needs and assets of people across NEL, and not constrained by geography

    (d) Taking our cue from the pandemic response, we will re-imagine how the NHS is led and run, to focus on collaboration, partnerships and relationships - reimagining the commissioning of the future with local authority partners - with commissioning functions at scale and place delivered in a much more integrated way with providers

    (e) Reach collective decisions about how to best use our resources to deliver outcomes at scale and at place. We can focus on reducing duplication, improving efficiency, and looking outward to those we serve.

Authority

12. The Collaborative Joint Committee is authorised by the Boards of the NHS Partner Organisations to take all necessary actions to fulfil the remit described within these terms of reference, including commissioning reports and creating groups. The Collaborative Joint Committee is permitted to establish sub-committees.

Role of the Collaborative Joint Committee

13. The Collaborative Joint Committee has been established in order to:

(a) Provide the NHS Partner Organisations with the ability to collaboratively direct and oversee the delivery of improved outcomes, quality, value and equity for people with or at risk of mental health conditions, learning disability and autism in north-east London;

(b) Ensure the development of further collaboration between the NHS Partner Organisations, with joint accountability for the delivery of the collaborative's aim;

(c) Ensure and encourage the involvement of the partner organisations of the ICS;

(d) Ensure that the views and expertise of residents with lived experience is at the heart of the collaborative's work;

(e) Ensure 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;

(f) Lead the development of the ICS strategy and planning for MHLDA services, and put in place arrangements to ensure its delivery with ICS partners including the seven place-based partnerships;

(g) Lead 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;

(h) Lead annual planning to meet the needs of people for mental health, MHLDA related services in North East London across the ICS;

(i) Provide assurance to the ICB on the delivery of the ICS strategy for MHLDA services, including population led priorities, and the NHS Long Term Plan; and agree mitigations where there are significant delivery risks;

(j) Enable the exercise of the Delegated Functions in a simple and efficient way (as outlined in **Annex 1**).

14. **Annex 1** lists the Delegated Functions, which have been delegated to Collaborative Joint Committee by the NHS Partner Organisations and, in relation to which, the Collaborative Joint Committee may take

decisions which shall be binding on each of the NHS Partner Organisations. It is expected that the arrangements described in these terms of reference will evolve, including to bring further functions within scope over time.

15. Annex 1 is divided into two respective parts, setting out the functions delegated by the ICB and the functions delegated by the provider NHS Partner Organisations.

16. The Delegated Functions shall be exercised with particular regard to the Collaborative's priorities and objectives, described in the MHLDA Services Plan, which the Collaborative Joint Committee shall approve on behalf of the NHS Partner Organisations. A summary of those priorities and objectives is contained at **Annex 2**.

17. In addition, the Collaborative Joint Committee will support the NHS Partner Organisations to achieve the aims and the ambitions of:

    (a) The Joint Forward Plan;

    (b) The Joint Capital Resource Use Plan;

    (c) The Integrated Care Strategy prepared by the NEL Integrated Care Partnership;

    (d) The joint local health and wellbeing strategies and associated needs assessments prepared by the eight health and wellbeing boards;

    (e) The plans prepared by the seven place-based partnerships, within the ICS's area;

    (f) The developing ICB Financial Framework.

18. The Collaborative Joint Committee will prioritise delivery against:

    (a) The strategic priorities of the ICS set out on the ICB's website, here;

    (b) Relevant plans and priorities developed by the NHS Partner Organisations.

19. In supporting the NHS Partner Organisations to discharge their statutory functions and deliver the strategic priorities of the ICS, the Collaborative Joint Committee will, in turn, be supporting the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to:

    (a) Improve outcomes in population health and healthcare;

    (b) Tackle inequalities in outcomes, experience and access;

    (c) Enhance productivity and value for money;

    (d) Help the NHS support broader social and economic development.

20. The Collaborative Joint Committee is also a key component of the ICS, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.

Chairing Arrangements

21. The Chair of the Collaborative Joint Committee will be the Joint Chair of NELFT and ELFT.

22. The Collaborative Joint Committee will nominate a deputy chair from amongst its members at its first meeting.

23. The term of office for the Chair and Deputy Chair will align to their tenure of appointment or following a significant change in the scope and function of the joint committee following an annual review, whichever is sooner.

24. The Chair (or in their absence, for all or part of a meeting for any reason, the Deputy Chair) will be responsible for agreeing the agenda, ensuring matters discussed meet the objectives as set out in these terms of reference, and escalating matters which require a decision by the Boards of the NHS Partner Organisations.

Membership

25. The Collaborative Joint Committee shall comprise the following members:

Chair of the meeting:

(a) Joint Chair of ELFT and NELFT

ICB:

(b) Chief Executive Officer

(c) Chief Finance and Performance Officer

(d) Chief Strategy and Transformation Officer

ELFT:

(e) Non-Executive Director

(f) Chief Executive Officer

(g) Executive Director of Integrated Care

(h) Chief Medical Officer

NELFT:

(i) Non-Executive Director

(j) Chief Executive Officer

(k) Executive Director of Partnerships

(l) Chief Nursing Officer

Local Authority:

(a) A Chief Executive/Executive Director of a local authority within the ICS area selected by the Chair

(b) CEO / Executive Director

Primary Care:

(c) An individual who can bring the perspective of primary care

Child and Adolescent Mental Health:

(d) An individual selected by the Chair who can bring the perspective of New Models of Care/ Mental Health Specialist Commissioning

VCSE sector:

(e) An individual selected by the Chair who can bring the perspective of the Voluntary, Community and Social Enterprise Sector

Lived Experience:

(a) Lived Experience Leader x 4

26. When determining the membership of the Collaborative Joint Committee, active consideration will be made to diversity and equality.

27. With the permission of the Chair of the Collaborative Joint Committee, the members of the Collaborative Joint Committee set out above may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.

Participants

28. The following individuals will have a standing invitation to attend meetings of the Collaborative Joint Committee, aside from in rare circumstances when the Chair determines that it is appropriate for only members of the Collaborative Joint Committee to be present:

(a) Representative, Healthwatch

29. The Collaborative Joint Committee may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This shall include other colleagues from the partner organisations within the ICS, professional advisors or others as appropriate, at the discretion of the Chair of the Collaborative Joint Committee.

Collaborative working and substructures

30. In exercising its responsibilities, the Collaborative Joint Committee shall work with other provider collaboratives, joint committees, committees, or sub-committees which have been established by the NHS Partner Organisations or wider partners of the ICS (e.g. voluntary, community

and faith sector organisations). This may include, where appropriate, aligning meetings or establishing joint working groups.

31. In particular, the Collaborative Joint Committee will, as appropriate, work with:

    (a) The place-based governance structures within the area of the ICS.

    (b) The NEL Acute Provider Collaborative, the NEL Community Services Collaborative, the NEL VCSE Collaborative and the NEL Primary Care Collaborative.

32. The Collaborative Joint Committee may delegate the Delegated Functions to sub-committees which it establishes in accordance with these terms of reference.

33. Where a function has been delegated by the Collaborative Joint Committee to a sub-committee it shall be recorded in **Annex 1.** All sub-committees established by the Collaborative Joint Committee must operate under terms of reference approved by the Joint Committee.

34. The Collaborative Joint Committee or its sub-committees may establish transformation boards, working groups or task and finish groups. All groups must operate under terms of reference approved by the Collaborative Joint Committee or the sub-committee which established them.

Key duties relating to the exercise of the Delegated Functions

35. When exercising any Delegated Functions, the Collaborative Joint Committee will ensure that it acts in accordance with, and that its decisions are informed by, the relevant policies and procedures which have been developed by the NHS Partner Organisations to support those functions and to inform the commissioning, provision and delivery of any relevant services.

36. When exercising a function which has been delegated by an NHS Partner Organisation, the Collaborative Joint Committee will have particular regard to the statutory obligations imposed on that organisation, and that organisation's policies and procedures. As particularly relevant to the Delegated Functions, these include, but are not limited to, the statutory duties set out in the 2006 Act. Key duties are listed in **Annex 3**. The NHS Partner Organisations will also have due regard to the public sector equality duty under section 149 of the Equality Act 2010.

37. All sub-committees or groups established within the collaborative's governance must also have due regard to the applicable statutory duties which apply to the NHS Partner Organisations.

Resource and financial management

38. The NHS Partner Organisations have made arrangements to support the Collaborative Joint Committee and the exercise of the Delegated Functions.

39. Further information about resource allocation and financial management is contained in the NHS Partner Organisations' standing financial instructions and associated policies and procedures, which includes the developing ICB Financial Framework. [The NHS Partner Organisations are currently working together to finalise the formal aspects of accountability and responsibility for financial decision-making for activities in scope of the APC Joint Committee, and will update the terms of reference once finalised.]

40. Financial decisions need to be made in line with the Standing Financial Instructions of the organisation at the source of funding; where this is multiple organisations this will need to be taken through all organisations' approval routes.

41. The Chair of the Joint Collaborative Committee will be invited to attend the ICB Finance Performance and Investment Committee where the committee is considering any issue relating to the resources allocated in relation to the Delegated Functions.

Collaborative Partnership Agreement

42. The NHS Partner Organisations are intending to enter into a partnership agreement to address a number of operational matters including:

    (a) Details of the operational resource to support the Collaborative Joint Committee to meet its responsibilities with regards to the Delegated Functions;

    (b) Risk and gain share agreements between the NHS Partner Organisations;

    (c) The process for commissioning / securing professional advice (including external advice);

    (d) Terms for withdrawal from the Collaboration Joint Committee;

    (e) Dispute resolution;

    (f) Information sharing;

    (g) Management of conflicts of interest;

    (h) Complaints handling.

43. The partnership agreement will supplement these terms of reference. To the extent that there is any conflict between the terms of reference and the agreement, these terms of reference shall prevail.

Meetings

Scheduling meetings

44. The Collaborative Joint Committee will ordinarily meet on a bi-monthly basis and, as a minimum, shall meet on five occasions each year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.

45. The Chair of the ICS, the Boards of the NHS Partner Organisations, or the ICB's Population Health and Integration ('**PH&I**') Committee may ask the Collaborative Joint Committee to convene further meetings to discuss particular issues on which they want the Collaborative Joint Committee's advice.

Quoracy

46. In order for a meeting to be quorate there must be at least seven members in attendance. This shall include:

    (a) Two members from each NHS Partner Organisation, and one such member should have clinical experience

    (b) One Lived Experience Leader

47. If any member of the Collaborative Joint Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Nominated deputies who have been authorised by the Chair shall count towards quorum.

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

Voting

49. The Collaborative Joint Committee will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the Collaborative Joint Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Collaborative Joint Committee will hold the casting vote. The result of the vote will be recorded in the minutes. Decisions taken shall be binding on each of the NHS Partner Organisations.

Papers and notice

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

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

Virtual attendance

52. It is for the Chair to decide whether or not the Collaborative Joint Committee will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually.

Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Admission of the public

53. Meetings of the Collaborative Joint Committee will usually be open to the public, unless the Chair determines that it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for some other good reason.

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

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

56. Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the Collaborative Joint Committee and others in attendance.

57. There shall be a section on the agenda for public questions to the Collaborative Joint Committee.

Recordings of meetings

58. Except with the permission of the Chair, no person admitted to a meeting of the Collaborative Joint Committee shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Minutes

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

Work plan

60. The Collaborative Joint Committee will approve a work plan which sets out how the forthcoming meetings of the Collaborative Joint Committee will be used to ensure the Delegated Functions are carried out effectively. This work plan will also take account of the work undertaken in other spaces connected to the work of the Collaborative Joint Committee, such as clinical networks, task and finish groups and other sub-groups of the committee, and sub-committees. The Collaborative Joint Committee will review the work plan annually. In its

first year of operation the work plan will also be reviewed after six months.

Governance support

61. Governance support to the Collaborative Joint Committee will be provided by the ICB's Governance team.

Confidential information

62. Where confidential information is presented to the Collaborative Joint Committee, all those present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.

Conflicts of interest

63. Conflicts of interests will be managed in accordance with the relevant policies, procedures and joint protocols developed by the ICS which shall be consistent with the NHS Partner Organisations' respective statutory duties and applicable national guidance.

Disputes

64. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the Collaborative Joint Committee in its capacity as a decision-making body, including uncertainty about whether the matter relates to:

    (a) a matter for determination by a board or other governance structure of an NHS Partner Organisation; or

    (b) determination by a placed-based committee of the ICB or another provider collaborative,

    then the matter will be referred to the relevant foundation trust's board in the case of a provider function, or the PH&I Committee or Board of the ICB in the case of an ICB function.

65. Where any other dispute arises between the NHS Partner Organisations, which is connected to the operation of the Collaborative Joint Committee and its work, this shall be resolved in accordance with the dispute resolution procedure which has been agreed between the NHS Partner Organisations.

Referral to the ICB's PH& I Committee

66. Where any decision before the Collaborative Joint Committee which concerns an ICB function is novel or contentious or repercussive across services which fall outside its remit, then the Collaborative Joint Committee shall give due consideration to whether the decision should be referred to the PH&I Committee of the ICB and reported to the ICB Board, as per the arrangements described at paragraphs 72-77 below. Where the Collaborative Joint Committee does decide to make such a referral, the Chair will action this on behalf of the Joint Committee.

67. Where a matter is referred to the PH&I Committee of the ICB under paragraph 66, the PH&I Committee (at an appropriate meeting) shall consider and determine whether to accept the referral and make a decision on the matter. Alternatively, the PH&I Committee may decide

to refer the matter to the Board of the ICB or to another appropriate part of the ICB's governance for determination. The PH&I Committee will keep the Chair of the Committee informed of its actions in relation to any referral from the Collaborative Joint Committee and the Chair shall in turn ensure that the Collaborative Joint Committee is keep updated.

68. In addition to the Collaborative Joint Committee's ability to refer a matter to the PH&I Committee, the Board of the ICB, its Chair and Chief Executive (acting together), may determine that any decision falling with paragraph 66 to the Board of the ICB.

Behaviours and Conduct

69. Members will be expected to behave and conduct business in accordance with:

    (a) The policies, procedures and governance documents that apply to them, including any jointly developed procedures or codes developed by the ICS;

    (b) The NHS Constitution;

    (c) The Nolan Principles.

70. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.

71. Members will seek to act in the best interests of the population of the ICS area, rather than representing the individual interests of the NHS Partner Organisations.

Accountability, reporting, and shared learning

72. The Collaborative Joint Committee is established by and ultimately accountable to the Boards of the NHS Partner Organisations and the Joint Committee shall report to the Boards accordingly through the provision of the information described at paragraph 74 below.

73. In addition to this, a committee of each Board will have operational oversight of the exercise of the relevant organisation's respective functions, namely:

    (a) The ICB's Population Health and Integration Committee;

    (b) ELFT's Integrated Care and Commissioning Committee;

    (c) NELFT's [Partnerships, Transformation and Performance Committee].

74. A copy of the meeting minutes along with a summary report shall be shared with the above three committees for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval.

75. The Collaborative Joint Committee will also report to the NHS Partner Organisations' committees for quality and finance, where its work is

relevant to the functions of those committees, or as otherwise requested by those committees.

76. **Annex 4** shows the Collaborative Joint Committee's governance, including its usual reporting lines.

Sharing learning and raising concerns

77. Where the Collaborative Joint Committee considers that an issue, or its learning from or experience of a matter, to be of importance or value to the North East London health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the ICB for onward referral to the PH&I Committee, the Chair or Chief Executive of the ICB, the Integrated Care Partnership or to one or more of ICB's committees or sub-committees as appropriate.

Review

78. The Collaborative Joint Committee will review its effectiveness at least annually and provide an annual report to the PH&I Committee and Boards of the NHS Partner Organisations on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference.

79. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Boards of the NHS Partner Organisations for approval.

Annex 1 – Delegated Functions

Part A: Functions delegated by the Board of the ICB

Role of the Collaborative Joint Committee:		Role of the joint committee's sub-committees [if any]:
MHLDA Services		
The Collaborative Joint Committee will have delegated responsibility for exercising the ICB's commissioning functions across the ICB's area in relation to mental health, learning disability and autism services, as specified below ('**MHLDA Services'**), in line with ICB policy. Where functions to be exercised by the Collaborative Joint Committee relate to a particular service, they must be exercised in line with the relevant commissioning policy for that service. The MHLDA Services are as follows: • [ ] The MHLDA Services do not, however, include: • [ ]		
Health and care needs planning		
The Collaborative Joint Committee will undertake the following specific activities in the domain of Planning in connection with health and care needs:		
1	Making recommendations to the PH&I Committee of the ICB in relation to, and contributing to, the Joint Forward Plan and Joint Capital Resource Use Plan and other system plans, in so far as relates to the provision of, and the need for, MHLDA Services in the ICB's area and the exercise of the ICB's functions.	
2	Overseeing, and providing assurance to the PH&I Committee regarding the implementation and delivery of the Joint Forward Plan, and Joint Capital Resource Use Plan, the Integrated Care Strategy and other system plans or strategies (including the joint local health and wellbeing strategies and associated needs assessments), in so far as they require the development and provision of MHLDA Services and the exercise of the ICB's functions.	
3	[Overseeing the development of service specification standards for the MHLDA Services, in line with ICB policies and procedures.]	
4	Developing and approving the MHLDA Services Plan and overseeing implementation and delivery of the plan, in so far as that requires the exercise of ICB functions.	

	The MHLDA Services Plan shall be developed by drawing on population health management tools and in coproduction with residents of North East London. It is aimed at ensuring delivery of the Joint Forward Plan, the Integrated Care Strategy and other system plans (including joint local health and wellbeing strategies and associated needs assessments), in so far as they require the development and provision of the MHLDA Services and the exercise of the ICB's functions. *In particular, this shall include the development and approval of the Collaborative priorities and objectives set out in Annex 2.* *The MHLDA Services Plan shall be tailored to meet particular local needs in specific places, where appropriate, but shall always maintain ICB-wide operational, quality and financial performance standards.*	
5	Reviewing plans developed by the seven place-based partnerships in relation to the provision of services relating to MHLDA, with a view to ensuring appropriate cohesion across the ICB area. This shall include reviewing such plans, making recommendations to the relevant Place ICB Committee and sharing learning.	
Workforce planning		
The Collaborative Joint Committee will undertake the following specific activities in the domain of Planning in connection with workforce matters:		
1	Approving demographic, service use and workforce modelling and planning, where these relate to MHLDA Services.	
Financial planning		
The Collaborative Joint Committee will undertake the following specific activities in the domain of Planning in connection with financial matters:		
1	[Making recommendations to the Finance Performance and Investment Committee or the Board of the ICB] in relation to: (a) The distribution of the following funds of the ICB: ○ The ICS Mental Health Investment Standard. ○ NHS Service Development Fund, in as much the fund shall apply to MHLDA Services. ○ Transforming Care budgets, in as much the fund shall apply to MHLDA Services. (b) Achieving best value and efficiencies across the ICB area (i.e. QIPP/CIP) with regard to the deployment of resources to support MHLDA Services.	
2	The ICB Finance, Performance and Investment Committee can ask the Collaborative Joint Committee to undertake the following activities: (a) Undertake reviews on overspends in relations to MHLDA budgets and to draw up a comprehensive action plan to ensure these are brought back to plan.	
Leadership and engagement		

The Collaborative Joint Committee will undertake the following specific activities in the domain of Leadership and engagement:		
1	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, MHLDA Services with a view to ensuring that such needs are considered within wider system planning.	
2	Providing leadership, on behalf of the ICB, on MHLDA related matters across the ICB's area, and working with ICS partners and NHS England as required. This shall include responsibility, on behalf of the ICB, for developing the vision and culture of the Collaborative, and engaging staff in that regard.	
3	Driving and overseeing citizen participation, in the development and delivery of MHLDA Services.	
4	Developing and coordinating clinical leadership for programmes to develop and deliver MHLDA Services.	
Governance		
The Collaborative Joint Committee will undertake the following specific activities in the domain of Governance:		
1	Responsibility on behalf of the ICB for developing the governance framework of the collaborative, including: • making recommendations to the ICB on the commissioning functions which should be within the scope of the collaborative; • establishing the sub-structures necessary to facilitate delivery of the Delegated Functions; • putting in place the documentation necessary to ensure robust governance and assurance; • leading on horizon scanning for examples of best practice, in relation to MHLDA collaboration.	
Transformation		
The Collaborative Joint Committee will undertake the following specific activities in the domain of Transformation:		
1	Co-ordinating the infrastructure for the delivery, on behalf of the ICB, of annual system operation plans (including demand management plans) in relation to MHLDA Services.	
2	Responsibility for directing system-wide transformation programmes relating to the provision and need for MHLDA Services, [including in relation to: • The configuration of adult mental health services • Crisis services • CAMHS transformation • Integrated PCN mental health teams	

	• Health-based places of safety.]	
3	Responsibility for identifying opportunities for improving outcomes, experience and value, and allocating programme management resources to support ICS-wide transformation programmes, involving MHLDA Services.	
4	Monitoring the delivery of place-based transformation programmes, involving MHLDA Services.	
5	Overseeing stakeholder involvement exercises relating to MHLDA Services, consistent with the ICB's statutory duties in this context and the ICB's relevant policies and procedures. Such stakeholder engagement shall include political engagement, clinical and professional engagement, strategic partnership management and public and community engagement.	
6	Overseeing the development and delivery of patient and public involvement activities, including public consultation, as part of any service change process relating to MHLDA Services.	
Performance, quality and finance		
The Collaborative Joint Committee will undertake the following specific activities in the domain of Performance, quality and finance:		
1	Providing assurance to the ICB that health outcomes, access to healthcare services and continuous quality improvement in relation to how MHLDA Services are being delivered across the ICB's area, escalating specific issues to the ICB and/or its finance, quality or other committees of the ICB as appropriate.	
2	Responsibility for liaising, and providing assurance to, NHS England on programme delivery relating to MHLDA Services.	
3	Responsibility for and providing assurance to the ICB in relation Transforming Care requirements, in relation to MHLDA Services.	
4	Responsibility for measurement of key outcome, quality and value metrics, employing Quality Improvement methodologies as appropriate.	
5	Complying with statutory reporting requirements relating to MHLDA Services, in particular as relates to quality and improvement of those services.	
6	Responsibility for and providing assurance to the Board of the ICB and the Finance, Performance and Investment Committee, in relation to the financial performance of activity within the Collaborative Joint Committee's remit. This shall include reporting on underspend/overspend and undertaking any financial remediation plans, as directed by the Board of the ICB or the Finance, Performance and Investment Committee.	

7	Responsibility for identifying new and emerging needs in the population(s) across the ICB's area relating to MHLDA - in particular, working with the Health and Wellbeing Boards in the ICB's area in the needs assessment process, as appropriate.	
Market management (including contracting)		
The Collaborative Joint Committee will undertake the following specific activities in the domain of Market Management:		
1	[To lead on a VCSE market development strategy across the ICB's area, in order to ensure there is provision available to support the delivery of the ICB's strategic priorities where connected with or requiring MHLDA Services.]	
2	Supply chain management and contract management and monitoring in relation to MHLDA Services, in line with ICB policies and procedures. In particular, this shall include: • Identifying opportunities for contracting more efficiently with non-NHS providers across the ICB's area, including responsibility for identifying duplication in existing provision of MHLDA Services. • Ensuring the ICB derives efficiencies and value for money from contracted and sub-contracted MHLDA Services. • Considering alignments of system approaches to social value and local supply chains in sub-contracting processes, in order to support broader economic and social development. Sharing best practice, across the ICS, based on local and national learning.	
	[Considering / Approving] contract design, contract award and procurement decisions where these relate specifically to MHLDA Services, in line with ICB policies and procedures.	
3	Responsibility for allocating resource to support procurement and contracting processes for services connected with MHLDA Services.	

Part B: Functions delegated by each of the Boards of ELFT and NELFT (for the purposes of this section, "the Trusts")

Role of the Collaborative Joint Committee:		Role of the joint committee's sub-committees [if any]:
Planning		
The Collaborative Joint Committee will undertake the following specific activities in the domain of Planning:		
1	Making recommendations to the Trusts' Boards in relation to, and contributing to, the Joint Forward Plan and Joint Capital Resource Use Plan, and other relevant system plans or strategies, in so far as relates to MHLDA Services.	
2	Developing and approving the MHLDA Services Plan and assuring implementation and delivery of the plan, in so far as that requires the development and provision of MHLDA Services and the relevant Trust's functions.	
3	Overseeing, and providing assurance to the Trusts' Boards regarding, the implementation and delivery of the Joint Forward Plan and Joint Capital Resource Use Plan, and other relevant system plans or strategies, in so far as they require the development and provision of MHLDA Services and the relevant Trust's functions.	
4	Providing information to the Trusts' Boards for the purposes of each Trust's duty to prepare its annual report for provision to NHS England, in so far as NHS England has requested, or those reports require, information connected with the MHLDA Services and the relevant Trust's functions.	
Transformation		
The Collaborative Joint Committee will undertake the following specific activities in the domain of Transformation:		
1	Overseeing any stakeholder involvement exercises relating exclusively to MHLDA Services, consistent with each Trust's statutory duty in this context and the Trusts' relevant policies and procedures. Such stakeholder engagement shall include political engagement, clinical and professional engagement, strategic partnership management and public and community engagement.	
2	Overseeing the development and delivery of patient and public involvement activities, including public consultation, as part of any service change process relating to MHLDA Services.	
Leadership and engagement		

The Collaborative Joint Committee will undertake the following specific activities in the domain of Leadership and engagement:		
1	Responsibility on behalf of the Trusts for engagement with partner organisations within the ICS (including primary care) on matters relating to the provision of, and the need for, MHLDA Services with a view to ensuring that such needs are considered within wider system planning.	
Performance, quality and finance		
The Collaborative Joint Committee will undertake the following specific activities in the domain of Performance, quality and finance:		
1	Providing assurance to the Trusts' Boards that continuous quality improvement in relation to MHLDA Services is being delivered across the ICB's area, escalating specific issues to the Trusts' Boards or relevant directors as appropriate.	
2	Responsibility for liaising, and providing assurance to, NHS England on programme delivery relating to MHLDA Services and the Collaborative's work.	
3	Responsibility for and providing assurance to the Trusts' Boards in relation Transforming Care requirements, in relation to MHLDA Services.	
4	Assisting the Trust Board, to comply with statutory reporting requirements relating to MHLDA Services, in particular as relate to quality and improvement of those services.	
5	Responsibility for and providing assurance to the Trusts' Boards, in relation to the financial performance of activity within the Collaborative Joint Committee's remit.	
Governance		
The Collaborative Joint Committee will undertake the following specific activities in the domain of Governance:		
1	Responsibility on behalf of the Trusts for developing the governance framework of the collaborative, including: • making recommendations to the Trust's Boards on the functions which should be within the scope of the Collaborative; • establishing the sub-structures necessary to facilitate delivery of the Delegated Functions; • putting in place the documentation necessary to ensure robust governance and assurance; • leading on horizon scanning for examples of best practice, in relation to MHLDA collaboration.	

Annex 2- Collaborative objectives and priorities

The following objectives and priorities are summarised from the current MHLDA Services Plan:

1	
2	
3	
4	

Annex 3 – Key statutory duties

Key duties of the ICB:

- Section 14Z32 – Duty to promote the NHS Constitution
- Section 14Z33 – Duty to exercise functions effectively, efficiently and economically
- Section 14Z34 – Duty as to improvement in quality of services
- Section 14Z35 – Duty as to reducing inequalities (and the separate legal duty under section 149 of the Equality Act 2010, the Public Sector Equality Duty)
- Section 14Z36 – Duty to promote involvement of each patient
- Section 14Z37 – Duty as to patient choice
- Section 14Z38 – Duty to obtain appropriate advice
- Section 14Z39 – Duty to promote innovation
- Section 14Z40 – Duty in respect of research
- Section 14Z41 – Duty to promote education and training
- Section 14Z41 – Duty to promote integration
- Section 14Z43 – Duty to have regard to the wider effect of decisions
- Section 14Z44 – Duties as to climate change etc
- Section 14Z45 – Public involvement and consultation (and the related duty under section 244 and the associated Regulations to consult relevant local authorities)
- Section 14Z30 – Registers of interests and management of conflicts of interest
- Section 223GB – Financial requirements on the ICB [where set by NHS England]
- Section 223GC – Financial duties of the ICB: expenditure
- Section 223L – Joint financial objectives for the ICB [where set by NHS England]
- Section 223M – Financial duties of the ICB: use of resources
- Section 223N – Financial duties of the ICB: additional controls on resource use
- Section 223LA – Financial duties of the ICB: expenditure limits

Key statutory duties of ELFT and NELFT:

- Section 63 - Duty to exercise functions effectively, efficiently and economically
- Section 63A - Duty to have regard to the wider effect of decisions

- Section 63B – Duties in relation to climate change
- Section 223L – Joint financial objectives [where set by NHS England]
- Section 223M – Financial duties: use of resources
- Section 223N – Financial duties: additional controls on resource use
- [Section 223LA – Financial duties: expenditure limits][2]
- Section 242 – Public involvement and consultation

[2] Statutory provision not yet in force.

Annex 4 – Governance Diagram

[Fuller governance diagram with reporting lines and a key to be inserted, with key to show reporting lines]

North East London Acute Provider Collaborative Joint Committee

TERMS OF REFERENCE
DRAFT

Introduction	1. The NHS North East London Integrated Care Board ('**ICB**') and the following NHS providers of acute services, who are all partners of the North East London Integrated Care System ('**ICS**'), have come together to form the North East London Acute Provider Collaborative ('**APC**'). 2. The NHS providers of acute services are: (a) Barts Health NHS Trust ('**Barts Health**') (b) Barking, Havering and Redbridge University Hospitals NHS Trust ('**BHRUT**') (c) Homerton Healthcare Hospital Foundation Trust ('**Homerton Healthcare**'). 3. For the purpose of these terms of reference, the providers and the ICB shall be known as the **'NHS Partner Organisations.'** 4. The APC Joint Committee, whose governance arrangements are described in these terms of reference, is the collective governance vehicle for joint decision-making by the NHS Partner Organisations in relation to acute services. 5. It 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, access and experience; improve resilience (e.g. by mutual aid); and ensure that specialisation and consolidation can occur where this will provide better outcomes and value.
Status	6. Section 65Z5 of the National Health Service Act 2006 (as amended) (the '**2006 Act'**) permits Integrated Care Boards, NHS trusts, and NHS foundation trusts to exercise their functions jointly with each other, subject to: (a) Regulations made by secondary legislation, which may constrain that joint exercise of functions, limit the power in relation to certain functions of one or more of those organisations, or impose conditions on the exercise of that power. (b) The expectations of statutory guidance about the exercise of this power, which is published by NHS England under section 65Z7 and which the NHS Partner Organisations must have regard to. 7. Section 65Z6 permits the organisations to arrange for the functions which are exercisable jointly to be exercised by a joint committee and, if they wish, for one or more of the organisations or the joint committee itself to establish and maintain a pooled fund.

	8. Arrangements made under section 65Z5 and section 65Z6 may be made on such terms as may be agreed between the organisations, including terms as to payment. 9. An NHS foundation trust is also permitted by section 47A of the 2006 Act to enter into arrangements for the carrying out, on such terms as it considers appropriate, of any of its functions jointly with any other person. NHS trusts have an equivalent power under paragraph 18 of Schedule 4 to the 2006 Act. 10. Integrated Care Boards also have powers under section 12ZA of the 2006 Act, in relation to arrangements they have made with service providers, which includes a power to confer discretions on those services providers. 11. By virtue of the powers described above, and in accordance with each of their constitutional and governance arrangements, the NHS Partner Organisations have formally established the APC Joint Committee.
Authority	12. The APC Joint Committee is authorised by the Boards of the NHS Partner Organisations to take all necessary actions to fulfil the remit described within these terms of reference, including commissioning reports and creating groups. The APC Joint Committee is permitted to establish sub-committees.
Role of the APC Joint Committee	13. The APC Joint Committee has been established in order to: (a) Provide the NHS Partner Organisations with the ability to collaboratively direct and oversee the delivery of high-quality patient care relating to acute services in North East London; (b) Ensure the development of further collaboration between the NHS Partner Organisations; (c) 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 ensure that people participation is at the heart of the activities of the APC's work; (d) 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; (e) Ensure and encourage the engagement of the partner organisations of the ICS, with a view to shaping the future of acute services across North East London; (f) Lead the development of the ICS strategy and planning for acute services, and put in place arrangements to ensure its delivery with ICS partners including the seven place-based partnerships; (g) Provide assurance to the NHS Partner Organisations on the delivery of the ICS's strategy and plans for acute services and the

NHS Long Term Plan, and agree mitigations where there are significant delivery risks;

(h) Enable the joint exercise of the functions which have been delegated to the APC Joint Committee by the NHS Partner Organisations, in a simple and efficient way ('the **Delegated Functions**').

14. In particular, the APC Joint Committee shall oversee and assure the work of the APC Executive which has been established as a sub-committee of the joint committee.

15. **Annex 1** lists the Delegated Functions, which have been delegated to the APC Joint Committee by the NHS Partner Organisations and, in relation to which, the APC Joint Committee may take decisions which shall be binding on each of the NHS Partner Organisations. It is expected that the arrangements described in these terms of reference will evolve, including to bring further functions within scope over time. For the avoidance of doubt, no party can delegate its functions into the APC Joint Committee without the agreement of all the NHS Partner Organisations.

16. Annex 1 is divided into two respective parts, setting out the functions delegated by the ICB and the functions delegated by the provider NHS Partner Organisations. It also records whether the APC Joint Committee has delegated a function to a sub-committee, and the sub-committee's role in respect of that function.

17. The Delegated Functions shall be exercised with particular regard to the APC Joint Committee's priorities and objectives, as described in the **APC Plan**, which the APC Joint Committee shall approve on behalf of the NHS Partner Organisations. A summary of the APC Joint Committee's priorities and objectives shall be contained at **Annex 2**.

18. In addition, the APC Joint Committee will support the NHS Partner Organisations to achieve the aims and the ambitions of:

(a) The Joint Forward Plan;

(b) The Joint Capital Resource Use Plan;

(c) The Integrated Care Strategy prepared by the NEL Integrated Care Partnership;

(d) The joint local health and wellbeing strategies and associated needs assessments prepared by the eight health and wellbeing boards;

(e) The plans prepared by the seven place-based partnerships, within the ICS's area; and

(f) The developing ICB Financial Framework.

19. The APC Joint Committee will prioritise its work against:

(a) The strategic priorities of the ICS and the ICS operating principles set out on the ICB's website, here;

(b) Relevant plans and priorities developed by the NHS Partner Organisations.

	20. In supporting the NHS Partner Organisations to discharge their statutory functions and deliver the strategic priorities of the ICS, the APC Joint Committee will, in turn, be supporting the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to: (a) Improve outcomes in population health and healthcare; (b) Tackle inequalities in outcomes, experience and access; (c) Enhance productivity and value for money; (d) Help the NHS support broader social and economic development. 21. The APC Joint Committee is also a key component of the ICS, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.
Chairing Arrangements	22. The Chair of the APC Joint Committee will be the Chair of Homerton Healthcare. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference. 23. The Deputy Chair of the APC Joint Committee will be Chair in Common of Barts Health and BHRUT.
Membership	24. The APC Joint Committee shall have the following members drawn from the NHS Partner Organisations, as follows: Barts Health/BHRUT roles: (a) Chair in Common (b) Group Chief Executive Officer / Accountable Officer for Barts Health and BHRUT (c) Executive Director for Barts Health and BHRUT (d) Joint Non-Executive Director Homerton Healthcare: (e) Chair (f) Chief Executive (g) Executive Director (h) Non-Executive Director ICB: (i) Chief Executive (j) Chief Finance and Performance Officer (k) Chief Medical Officer 25. When determining the membership of the APC Joint Committee, active consideration will be made to diversity and equality.

	26. With the permission of the Chair of the APC Joint Committee, the members of the APC Joint Committee set out above may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.
Participants	27. The APC Collaboration Director will have a standing invitation to attend meetings of the APC Joint Committee, aside from in rare circumstances when the Chair determines that it is appropriate for only members of the APC Joint Committee to be present. 28. The APC Joint Committee may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This shall include other colleagues from the partner organisations within the ICS, professional advisors or others as appropriate, at the discretion of the Chair of the APC Joint Committee. In particular, the APC Joint Committee may invite: (a) The Senior Responsible Officers for the APC programmes; (b) Individuals who can bring the perspective of the local authorities in North East London; the Voluntary, Community and Social Enterprise sector; Healthwatch; Patients and services users.
Collaborative working and substructures	29. In exercising its responsibilities, the APC Joint Committee shall work with other provider collaboratives, joint committees, committees, or sub-committees which have been established by the NHS Partner Organisations or wider partners of the ICS. This may include, where appropriate, aligning meetings or establishing joint working groups. 30. In particular, the APC Joint Committee will, as appropriate, work with: (a) The place-based governance structures within the ICS; (b) The North East London MHLDA Collaborative, the North East London Community Health Collaborative, the North East London VCSE Collaborative and the North East London Primary Care Collaborative. 31. The APC Joint Committee may delegate any of the Delegated Functions to the APC Executive and any other sub-committees which it establishes in accordance with these terms of reference. 32. Where a function has been delegated by the APC Joint Committee to a sub-committee it shall be recorded in **Annex 1.** All sub-committees established within the APC's governance must operate under terms of reference approved by the APC Joint Committee. 33. The APC Joint Committee or its sub-committees may establish transformation boards, working groups or task and finish groups. All groups established within the APC's governance must operate under terms of reference approved by the APC Joint Committee or the APC sub-committee which established them.

Key duties relating to the exercise of the Delegated Functions	34. When exercising any Delegated Functions, the APC Joint Committee will ensure that it acts in accordance with, and that its decisions are informed by, the relevant policies and procedures which have been developed by the NHS Partner Organisations to support those functions and to inform the commissioning, provision and delivery of any relevant services. 35. When exercising a function which has been delegated by an NHS Partner Organisation, the APC Joint Committee will have particular regard to the statutory obligations imposed on that organisation, and that organisation's policies and procedures. As particularly relevant to the Delegated Functions, these include, but are not limited to, the statutory duties set out in the 2006 Act. Key duties are listed in **Annex 3.** The NHS Partner Organisations will also have due regard to the public sector equality duty under section 149 of the Equality Act 2010. 36. All sub-committees or groups established within the APC's governance must also have due regard to the applicable statutory duties which apply to the NHS Partner Organisations.
Resource and financial management	37. The NHS Partner Organisations have made arrangements to support the APC and the exercise of the Delegated Functions. 38. Further information about resource allocation and financial management is contained in the NHS Partner Organisations' standing financial instructions and associated policies and procedures, which includes the ICB Financial Framework. The NHS Partner Organisations are currently working together to finalise the formal aspects of accountability and responsibility for financial decision-making for activities in scope of the APC Joint Committee, and will update the terms of reference once finalised. 39. Financial decisions need to be made in the line with the Standing Financial Instructions of the organisation at the source of the funding; where this is multiple organisations this will need to be taken through all organisations' approval routes.
APC Partnership Agreement	40. In due course, the NHS Partner Organisations will consider entering into a partnership agreement to address operational matters including: (a) Details of the operational resource to support the APC Joint Committee to meet its responsibilities with regards to the Delegated Functions; (b) Risk and gain share agreements between the NHS Partner Organisations; (c) The process for commissioning / securing professional advice (including external advice); (d) Terms for withdrawal from the APC Joint Committee; (e) Dispute resolution; (f) Information sharing; (g) Management of conflicts of interest;

	(h) Complaints handling. 41. The partnership agreement will supplement these terms of reference. To the extent that there is any conflict between the terms of reference and the agreement, these terms of reference shall prevail.
Meetings	*Scheduling meetings* 42. The APC Joint Committee will ordinarily meet quarterly, and, as a minimum, shall meet on three occasions each year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair. 43. The Chair of the ICS, the Boards of the NHS Partner Organisations, or the ICB's Population Health and Integration ('PH&I') Committee may ask the APC Joint Committee to convene further meetings to discuss particular issues on which they want the APC Joint Committee's advice. *Quoracy* 44. In order for a meeting to be quorate there must be at least six members in attendance, which shall include a non-executive and an executive from each of Homerton Healthcare, the ICB and the collaboration between Barts Health and BHRUT. 45. If any member of the APC Joint Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Nominated deputies who have been authorised by the Chair shall count towards quorum. 46. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. *Voting* 47. The APC Joint Committee will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the APC Joint Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the APC Joint Committee will hold the casting vote. The result of the vote will be recorded in the minutes. Decisions taken shall be binding on each of the NHS Partner Organisations. *Papers and notice* 48. A minimum of seven clear days' notice and dispatch of meeting papers is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting. 49. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as

	possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair. *Virtual attendance* 50. It is for the Chair to decide whether or not the APC Joint Committee will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes. *Recordings of meetings* 51. Except with the permission of the Chair, no person admitted to a meeting of the APC Joint Committee shall be permitted to record the proceedings in any manner whatsoever, other than in writing. *Minutes* 52. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the APC Joint Committee together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Chair. *Governance support* 53. Governance support to the APC Joint Committee will be provided by the ICB's Governance Team. *Confidential information* 54. Where confidential information is presented to the APC Joint Committee, all attendees will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.
Conflicts of interest	55. Conflicts of interests will be managed in accordance with relevant policies, procedures and joint protocols developed by the ICS, which shall be consistent with the NHS Partner Organisations' respective statutory duties and applicable national guidance.
Disputes	56. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the APC Joint Committee in its capacity as a decision-making body, including uncertainty about whether the matter relates to: (a) a matter for determination by a Board or other governance structure of an NHS Partner Organisations; or

	(b) determination by a placed-based committee of the ICB or another provider collaborative, then the matter will be referred to the relevant Trusts' Board in the case of a provider function, or the PH&I Committee or Board of the ICB in the case of an ICB function. 57. Where any other dispute arises between the NHS Partner Organisations, which is connected to the operation of the APC and its work, this shall be resolved in accordance with the dispute resolution procedure which has been agreed between the NHS Partner Organisations.
Referral to the ICB's Population Health & Integration Committee	58. Where any decision before the APC Joint Committee which concerns an ICB function is novel or contentious or repercussive across services which fall outside its remit, then the APC Joint Committee shall give due consideration to whether the decision should be referred to the PH&I Committee of the ICB and reported to the ICB Board, as per the arrangements described at paragraphs 64-69 below. Where the APC Joint Committee does decide to make such a referral, the Chair will action this on behalf of the APC Joint Committee. 59. Where a matter is referred to the PH&I Committee under paragraph 58, the Committee (at an appropriate meeting) shall consider and determine whether to accept the referral and make a decision on the matter. Alternatively, the PH&I Committee may decide to refer the matter to the Board of the ICB, one its committees or subcommittees, or to a joint committee or other collaborative for determination. The PH&I Committee will keep the Chair of the Committee informed of its actions in relation to any referral from the APC Joint Committee and the Chair shall in turn ensure that the APC Joint Committee is keep updated. 60. In addition to the APC Joint Committee's ability to refer a matter to the PH&I Committee of the ICB, the Board of the ICB, or its Chair and the Chief Executive (acting together), may also require a referral of any decision falling with paragraph 58 to the Board of the ICB.
Behaviours and Conduct	61. Members will be expected to behave and conduct business in accordance with: (a) The policies, procedures and governance documents that apply to them, including any jointly developed procedures or codes developed by the ICS. (b) The NHS Constitution; (c) The Nolan Principles. 62. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.

	63. Members will seek to act in the best interests of the population of the ICS area, rather than representing the individual interests of the NHS Partner Organisations.
Accountability, reporting, and shared learning	64. The APC Joint Committee is established by and ultimately accountable to the Boards of the NHS Partner Organisations and the Joint Committee shall report to the Boards accordingly through the provision of the information described at paragraph 66 below. 65. In addition to this, a committee of each of the NHS Partner Organisations' Boards may be given operational oversight of the exercise of the relevant organisation's respective functions. This includes: (a) The ICB's Population Health and Integration Committee in respect of the ICB functions. 66. A copy of the meeting minutes along with a summary report shall be shared with the above committee(s) for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval. 67. The APC Joint Committee will also report to the NHS Partner Organisations' committees for quality and finance, where its work is relevant to the functions of those committees, or as otherwise requested by those committees. 68. **Annex 4** shows the APC Joint Committee's governance, including its usual reporting lines. *Sharing learning and raising concerns* 69. Where the APC Joint Committee considers that an issue, or its learning from or experience of a matter, to be of importance or value to the North East London health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the ICB for onward referral to the PH&I Committee, the Chair or Chief Executive of the ICB, the Integrated Care Partnership or to one or more of ICB's committees or subcommittees as appropriate.
Review	70. The APC Joint Committee will review its effectiveness at least annually and provide an annual report to the PH&I Committee and Boards of the NHS Partner Organisations on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference. 71. These terms of reference, including membership and chairing arrangements, will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Boards of the NHS Partner Organisations for approval.

Annex 1 – Delegated Functions (for the commencement of year one)

Part A: Functions delegated by the Board of the ICB

Role of the APC Joint Committee:		Role of the APC Executive:
Planning		
The APC Joint Committee will undertake the following specific activities in the domain of Planning:		-
1	Making recommendations to the PH&I Committee of the ICB 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, acute services in the ICB's area and the exercise of the ICB's functions.	To prepare such recommendations for consideration by the APC Joint Committee.
2	Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery of the Joint Forward Plan, and Joint Capital Resource Use Plan, the Integrated Care Strategy and other system plans or strategies (including the joint local health and wellbeing strategies and associated needs assessments), in so far as they require the exercise of ICB functions relating to acute services.	To monitor implementation and report to the APC Joint Committee, as appropriate.
3	Developing and approving the APC Plan and assuring implementation and delivery of the plan, in so far as that requires the exercise of ICB functions. *The APC Plan shall be developed by drawing on population health management tools and in coproduction with service users and residents of North East London. It is aimed at ensuring delivery of the Joint Forward Plan, the Integrated Care Strategy and other system plans (including joint local health and wellbeing strategies and associated needs assessments), in so far as they require the exercise of functions relating to acute services.* *In particular, this shall include the development and approval of the APC's priorities and objectives set out in Annex 2.* *The APC Plan shall be tailored to meet particular local needs in specific places, where appropriate, but shall always maintain ICB-wide operational, quality and financial performance standards.*	To lead on developing and preparing the plan for approval by the APC Joint Committee, and overseeing its implementation.
4	Reviewing plans developed by the seven place-based partnerships in relation to the provision of services relating to acute services, with a view to ensuring appropriate cohesion across the ICB area. This shall include reviewing such plans, making recommendations to the relevant Place ICB Committee and sharing learning.	To lead on such matters.
Leadership and engagement		

The APC Joint Committee will undertake the following specific activities in the domain of Leadership and engagement:		-
1	Responsibility on behalf of the ICB for engagement with partner organisations within the ICS (including primary care) on matters relating to acute services with a view to ensuring that such needs are considered within wider system planning.	To lead on such matters.
2	Providing leadership, on behalf of the ICB, on matters relating to acute services across the ICB's area, and working with ICS partners and NHS England as required. This shall include responsibility, on behalf of the ICB, for developing the vision and culture of the Collaborative, and engaging staff in that regard.	To lead on such matters.
3	Driving and overseeing service user and citizen participation, in relation to the exercise of ICB functions relating to acute services.	[ ]
Governance		
The APC Joint Committee will undertake the following specific activities in the domain of Governance:		-
1	Responsibility on behalf of the ICB for developing the governance framework of the APC, including: • making recommendations to the ICB on the commissioning functions which should be within the scope of the APC; • establishing the sub-structures necessary to facilitate delivery of the Delegated Functions; • putting in place the documentation necessary to ensure robust governance and assurance.	To make recommendations to the APC Joint Committee in relation to such matters. Leading on horizon scanning for examples of best practice.

Part B: Functions delegated by each of the Boards of Barts Health, BHRUT and Homerton Healthcare (for the purposes of this section, "the Trusts")

Role of the APC Joint Committee:		**Role of the APC Executive:**
Planning		
The APC Joint Committee will undertake the following specific activities in the domain of Planning:		-
1	Making recommendations to the Trusts' Boards in relation to, and contributing to, the Joint Forward Plan and Joint Capital Resource Use Plan, and other relevant system plans or strategies, in so far as it relates to the provision of, and the need for, acute services in the ICB's area and exercise of the Trusts' functions.	To prepare such recommendations for consideration by the APC Joint Committee.

2	Developing and approving the APC Plan and assuring implementation and delivery of the plan, in so far as that requires the exercise of the relevant Trust's functions.	To lead on developing and preparing the plan for approval by the APC Joint Committee, and overseeing its implementation.
3	Overseeing, and providing assurance to the Trusts' Boards regarding, the implementation and delivery of the Joint Forward Plan and Joint Capital Resource Use Plan, and other relevant system plans or strategies, in so far as they require the exercise of the APC functions.	To monitor implementation and report to the APC Joint Committee, as appropriate.
4	Providing information to the Trusts' Boards for the purposes of each Trust's duty to prepare its annual report for provision to NHS England, in so far as NHS England has requested, or those reports require, information connected with the exercise of the APC's functions.	[ ]
Leadership and engagement		
The APC Joint Committee will undertake the following specific activities in the domain of Leadership and engagement:		-
1	Responsibility on behalf of the Trusts for engagement with partner organisations within the ICS (including primary care) on matters relating to the provision of, and the need for, acute Services with a view to ensuring that such needs are considered within wider system planning.	To lead on such matters.
Governance		
The APC Joint Committee will undertake the following specific activities in the domain of Governance:		-
1	Responsibility on behalf of the Trusts for developing the governance framework of the APC, including: • making recommendations to the Trusts' Board on the functions which should be within the scope of the APC, • establishing the sub-structures necessary to facilitate delivery of the Delegated Functions; • putting in place the documentation necessary to ensure robust governance and assurance.	To make recommendations to the APC Joint Committee in relation to such matters. Leading on horizon scanning for examples of best practice.

Annex 2- APC Joint Committee objectives and priorities

The following priorities and objectives are summarised from the current APC Plan:

1	*[To be populated once plan developed]*
2	
3	
4	

Annex 3 – Key statutory duties

Key duties of the ICB:

- Section 14Z32 – Duty to promote the NHS Constitution
- Section 14Z33 – Duty to exercise functions effectively, efficiently and economically
- Section 14Z34 – Duty as to improvement in quality of services
- Section 14Z35 – Duty as to reducing inequalities (and the separate legal duty under section 149 of the Equality Act 2010, the Public Sector Equality Duty)
- Section 14Z36 – Duty to promote involvement of each patient
- Section 14Z37 – Duty as to patient choice
- Section 14Z38 – Duty to obtain appropriate advice
- Section 14Z39 – Duty to promote innovation
- Section 14Z40 – Duty in respect of research
- Section 14Z41 – Duty to promote education and training
- Section 14Z41 – Duty to promote integration
- Section 14Z43 – Duty to have regard to the wider effect of decisions
- Section 14Z44 – Duties as to climate change etc
- Section 14Z45 – Public involvement and consultation (and the related duty under section 244 and the associated Regulations to consult relevant local authorities)
- Section 14Z30 – Registers of interests and management of conflicts of interest
- Section 223GB – Financial requirements on the ICB [where set by NHS England]
- Section 223GC – Financial duties of the ICB: expenditure
- Section 223L – Joint financial objectives for the ICB [where set by NHS England]
- Section 223M – Financial duties of the ICB: use of resources
- Section 223N – Financial duties of the ICB: additional controls on resource use
- [Section 223LA – Financial duties of the ICB: expenditure limits]

Key statutory duties of Barts Health, BHRUT, Homerton:

Foundation trusts

- Section 63 - Duty to exercise functions effectively, efficiently and economically
- Section 63A - Duty to have regard to the wider effect of decisions
- Section 63B – Duties in relation to climate change

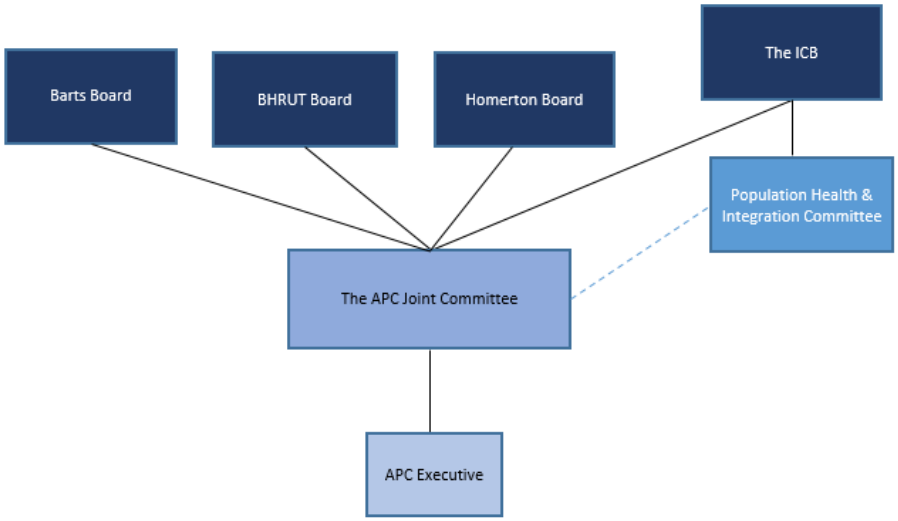
Trusts

- Section 26 - Duty to exercise functions effectively, efficiently and economically
- Section 26A - Duty to have regard to the wider effect of decisions
- Section 26B – Duties in relation to climate change

Foundation trusts and trusts

- Section 223L – Joint financial objectives [where set by NHS England]
- Section 223M – Financial duties: use of resources
- Section 223N – Financial duties: additional controls on resource use
- [Section 223LA – Financial duties: expenditure limits]
- Section 242 – Public involvement and consultation

Annex 4 – Governance Diagram



[*Drafting note:* A fuller governance diagram with reporting lines and a key will be inserted, and can include any other relevant committees, e.g. of the Trusts]

North East London
Integrated Care Board

Primary Care Contracts Sub-Committee

DRAFT TERMS OF REFERENCE

Status	1. The Board of the ICB has established the Finance Performance and Investment Committee (the "**FPIC**") and, in turn, the Primary Care Contracts Sub-Committee ("the **sub-committee**") has been formally established as a sub-committee of the FPIC. 2. These Terms of Reference set out the membership, the remit, responsibilities and reporting arrangements of the sub-committee and may only be changed with the approval of the FPIC and the Board. Additionally, the membership of the sub-committee must be approved by the Chair of the Board. 3. The sub-committee and all of its members are bound by the ICB's Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB.
Authority	4. The sub-committee is authorised by the Board to take all necessary actions to fulfil the remit described within these terms of reference, including obtaining professional (including legal) advice, commissioning reports and creating groups. The sub-committee will follow the processes described by the Board for commissioning any professional advice. 5. The sub-committee does not have the authority to delegate any functions delegated to it. However, the sub-committee may establish groups (e.g. working, advisory or task and finish groups), which do not have any decision-making powers but may inform the work of the sub-committee. Such groups must operate under terms of reference approved by the sub-committee, and these must reflect appropriate arrangements for the management of conflicts of interest.
Purpose and geographic scope	6. The sub-committee is established to oversee and assure the ICB's primary care commissioning and contracting functions. This includes functions in relation to primary medical services, and to pharmaceutical, ophthalmic, and dental services ('**PODS**') delegated to the ICB from NHS England. 7. The ICB's functions in relation to primary medical services relate to the area of North East London only (i.e. the ICB's area). However, its remit over PODS is wider: as described in the Memorandum of Understanding between the London five ICBs ('the **MOU**') which can be found in the table at **Annex 1** to these terms of reference, the ICB will assume certain responsibilities for co-ordinating the commissioning and contracting of PODS on its own behalf, and as the Host ICB on behalf of:

(a) NHS North Central London ICB

(b) NHS North West London ICB

(c) NHS South East London ICB

(d) NHS South West London ICB

8. As described in paragraphs 12 to 14 below, the sub-committee will oversee and assure the discharge by the ICB of its pan-London responsibilities.

Responsibilities of the sub-committee in relation to primary medical services

9. The role of the sub-committee shall be to oversee the exercise of 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 Delegation Agreement'**), which can be found at **Annex 1.**[1]

10. Specific matters delegated to the sub-committee (including any matters delegated by NHS England to the ICB) are set out in the ICB's operational scheme of delegation for Primary Care, which is in the Handbook. The sub-committee is authorised by the ICB to take decisions in relation to those matters.

11. This includes the following:

(a) Overseeing arrangements for ensuring effective primary medical services contract management.

(b) Overseeing the design and commissioning of any enhanced services.

(c) Overseeing the design and offer local incentive schemes as an alternative to the Quality Outcomes Framework (QOF) or enhanced services.

(d) Overseeing the development of commissioning proposals for urgent care for out of area registered patients, ensuring compliance with any mandated guidance in relation to the design and commissioning of these services.

(e) Oversee the development of plans regarding the primary medical services provide landscape, and taking decisions in relation to:

- Establishing new primary medical services providers.
- Approving practice mergers and closures.
- Dispersing patient lists.
- Agreeing boundary variations.

[1] For primary medical services, see Schedule 2A in particular.

- The procurement/award of new contracts (subject to financial limits).

(f) Overseeing arrangements for commissioning PCN Contract Direct Enhanced Services.

(g) Overseeing arrangements for commissioning ancillary support services.

(h) Overseeing arrangements for managing primary medical services providers providing inadequate standards of care.

(i) Making decisions on discretionary payments and discretionary support (e.g. returner/retainer schemes).

Responsibilities of the sub-committee in relation to PODS

Pan-London PODS

12. As the Host ICB, the ICB is required to ensure that the responsibilities it takes on under section 7 of the MoU, "Responsibilities Delegated to the Host ICB", have been appropriately discharged, as per section 7.2 of the MOU. In doing so, the sub-committee will liaise as appropriate with, and seek advice or a steer from, the POD Commissioning Oversight Group ('**COG**')[2] whose terms are contained within the MOU at **Annex 1**.

13. The sub-committee's role is to assure that the responsibilities are appropriately discharged. Day-to-day oversight and responsibility for the appropriate discharge of the ICB's responsibilities for PODS described above sits with the ICB's Managing Director for Primary Care, *NEL PODS.*

14. In addition, to assuring the discharge by the ICB of its pan-London responsibilities, the sub-committee shall assure the exercise of functions by the ICB relating to the commissioning and management of PODS for the ICB's population, in accordance with:

(a) The Delegation Agreement.[3]

(b) Section 9 of the MOU, which sets out responsibilities relating to PODS which are retained by each of the five ICBs.

(c) Section 12 of the MOU, which requires the ICB to follow certain financial arrangements in relation to its financial allocation for PODS.

15. The sub-committee will not routinely be expected to make commissioning and contracting decisions on how the ICB's individual allocation for PODs is spent. Such decisions will be taken in accordance with section 12.12 of the MOU.

[2] COG has been established to enable certain functions in relation to PODS to be discharged in a collective forum of the five ICBs. The responsibilities to be discharged collectively and managed through COG are described in section 8 of the MOU and COG is further described at section 11 of the MOU.

[3] For PODS, see in particular: Schedule 2B (Primary Dental Services); Schedule 2C (Primary Ophthalmic Services); Schedule 2D (Primary Pharmaceutical Services).

Facilitating assurance

16. The sub-committee's assurance responsibilities will be facilitated by:

    (a) Attendance of the Managing Director for Primary Care at meetings of the sub-committee.

    (b) Written summary reports from the Managing Director for Primary Care which shall be provided to the sub-committee on a quarterly basis. Such reports shall focus on areas of risk, and key points of debate, actions and decisions taken within the forum of COG or otherwise in relation to PODS.

    (c) Reports or other outputs which are shared with the sub-committee by COG.

17. Financial management in relation to PODS will be assured through the sub-committee, which may escalate matters to FPIC on the advice of the Chief Finance and Performance Officer. Where appropriate, the sub-committee may also refer such matters for discussion at COG.

Key duties relating the exercise of the sub-committee's functions

18. Where such functions have been delegated to the ICB by NHS England, as set out in the Delegation Agreement, the sub-committee shall ensure that it adheres to the agreement at all times and the requirements of any assurance arrangements made by NHS England.

19. The Delegation Agreement imposes wide-ranging contractual obligations and refers to relevant guidance documents, policy and expectations, and Mandated Guidance issued by NHS England from time-to-time.[4] In certain circumstances, decisions may require the approval of the ICB's Chief Executive Office or Chief Finance and Performance Officer and require approval of NHS England in accordance with the financial limits set out in the Delegation Agreement, which includes where a matter in relation to the Delegated Functions is *novel contentious or repercussive*[5]. The sub-committee will ensure that it takes advice on any matter where these requirements may apply and escalate matters as appropriate.

20. In relation to PODS, the sub-committee shall also take into account any advice, guidance or recommendations made by COG.

Collaboration and Alignment with Wider System Primary Care Governance

21. The sub-committee will work closely with:

    (a) The Primary Care Collaborative and any groups it establishes.

    (b) Governance structures in the seven places, which have a remit over primary care, in the context of the financial framework.

    (c) COG and any other governance structures established for the purposes of PODS in London.

[4] See Schedule 9 of the Delegation Agreement.
[5] See Schedule 5 of the Delegation Agreement.

	(d) The NEL Primary Care Quality Group. This shall include the ability to ask those governance structures to support it in the exercise of its functions and to receive recommendations from them in order to inform decisions, as appropriate.
Chairing arrangements	22. The sub-committee will be chaired by the Chief Finance and Performance Officer or nominated deputy appointed on account of their specific knowledge, skills and experiences making them suitable to chair the sub-committee and will agree the sub-committee's agenda and ensure that its work and discussions meet the objectives set out in these terms of reference. 23. Sub-committee members may appoint a Vice Chair from amongst the members. If the Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the sub-committee will be responsible for deciding the appropriate course of action.
Membership	24. The sub-committee members shall be appointed by the Board in accordance with the ICB Constitution and the Chair of the ICB will approve the membership of the sub-committee. 25. The sub-committee shall have 5 members as follows: (a) Chief Finance and Performance Officer or nominated deputy (**Chair**) (b) Chief Medical Officer or nominated clinical deputy (c) Chief Nurse Officer or nominated quality clinical deputy (d) Managing Director of Primary Care (e) Associate Non-Executive Member (**Vice Chair**)
Participants	26. Only members of the sub-committee have the right to attend meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the sub-committee. 27. The following will have a standing invitation to attend meetings of the sub-committee: (a) The Associate Medical Director. (b) Representatives from Healthwatch and the Local Medical Committee (London-wide and Barking & Dagenham and Havering), Local Dental Committee, Local Optical Committee and Local Pharmaceutical Committee. 28. The sub-committee may, invite others to attend meetings to support the sub-committee in discharging its responsibilities (e.g. Senior Managers, members of the POD Commissioning Team, members of COG).

Meetings Quoracy and Decisions

29. The sub-committee will operate in accordance with the ICB's governance framework, as set out in its Constitution and Handbook and wider ICB policies and procedures, except as otherwise provided below:

Scheduling meetings

30. The sub-committee shall ordinarily meet on a bi-monthly basis, with six meetings each financial year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.

31. The Board, Chair, Chief Executive or FPIC may ask the sub-committee to convene further meetings to discuss particular issues on which they want the sub-committee's advice.

Quoracy

32. For a meeting to be quorate there must be three members present, which must include:

    (a) Either the Chair or Vice Chair;

    (b) One Chief Officer or their nominated deputy.

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

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

Voting

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

Papers and notice

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

37. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent virtual meeting by email or MS teams shall be permitted in exceptional circumstances (i.e. remedial action) at the discretion of the Chair.

Virtual attendance

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

Recordings of meetings

39. Except with the permission of the Chair, no person admitted to a meeting of the sub-committee shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Confidential information

40. Where confidential information is presented to the sub-committee, all those who are present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles. This includes any information governance requirements expected of the ICB under the Delegation Agreement (e.g. clauses 17 and 21) and the MOU (e.g. clause 22).

Meeting minutes

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

Governance support

42. Governance support to the sub-committee will be provided by the ICB's governance team.

Conflicts of interest

43. Conflicts of interest will be managed in accordance with the policies and procedures of the ICB and those contained in the Handbook and shall be consistent with the statutory duties contained in the National Health Service Act 2006 and any statutory guidance issued by NHS England.

44. The ICB acknowledges that it shall comply with sections 17 and 23 of the MOU which, in summary, requires the ICB to:

    (a) Openly declare conflicts of interest in any decision-making forum convened for the purposes of making a decision under the provisions of the MOU.

	(b) Comply with relevant guidance and maintain a publicly available register of interests in respect of all persons making decisions concerning the functions set out in the MOU.
Behaviours and Conduct	45. Members will be expected to behave and conduct business in accordance with: (a) The ICB's policies and procedures including its Constitution, Standing Orders and Standards of Business Conduct Policy; which sets out the expected behaviours that all members of the Board and its committees will uphold whilst undertaking ICB business; (b) The NHS Constitution; (c) The Nolan Principles; 46. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.
Accountability and Reporting	47. The sub-committee is accountable to the FPIC and shall report to the FPIC on how it discharges its responsibilities. 48. The sub-committee will submit copies of its minutes and a report to the FPIC following each of its meetings. 49. The sub-committee will provide the FPIC with an annual report. The report will summarise its conclusions from the work it has done during the year.
Review	50. The sub-committee will review its effectiveness at least annually. 51. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the FPIC and the Board for approval.

Date of approval:	31 October 2022 (by the Finance, Performance and Investment Committee)
Date of review	1 April 2024
Version:	2.0

Annex 1 – Key Documents

Delegation Agreement	https://northeastlondon.icb.nhs.uk/wp-content/uploads/2023/07/NEL-Primary-Care-and-Dental-Delegation-Agreement-FINAL.pdf
Memorandum of Understanding (PODS), including the Terms of Reference for the Commissioning Oversight Group	 MOU POD Services London.pdf  London POD Commissioning Ove
London Operating Model for PODS	[in development]

Scheme of Reservation and Delegation

Category	ICB Decision	ICB Decision Route
Regulation and Control	Consideration and approval of applications to NHS England (NHSE) on any matter concerning material changes to the ICB Constitution or as otherwise required	Board
	Exercising any other functions of the ICB which have not been retained as reserved by the ICB Board.	Board
	Approval of the ICB's Scheme of Reservation and Delegation.	Board
	Approve amendments to the Standing Orders (SOs), subject to approval by NHS England given SOs are in the Constitution (see above).	Board
	Reviewing the ICB's governance arrangements to ensure that the ICB continues to reflect the principles of good governance.	Board
	Approve amendments to the terms of reference of committees of the ICB (on recommendation from each committee)	Board
	Approve detailed standing financial instructions and the finance scheme of delegation.	Board
	Approve arrangements for managing exceptional funding requests	Finance, Performance and Investment Committee
	Approve any changes to the provision or delivery of internal and external audit services to the ICB.	Audit and Risk Committee
	Exercise the powers that the ICB has reserved to itself in an emergency or for an urgent decision.	ICB Chief Executive and Chair
	Set out who can execute a document by signature and seal.	Chief Finance and Performance Officer
Strategic Planning	Agree the vision, values and overall strategic direction of the ICB.	Board
	Approval of the ICB's Operating Plan.	Board

Category	ICB Decision	ICB Decision Route
	Approval of the ICB's corporate budgets that meet the financial duties as set out in the Constitution	Board
	Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the ICB's ability to achieve its agreed strategic aims	Board
	Approve the annual capital plan	Board
	Monitoring performance of the ICB against its plans including statutory finance and performance targets	Finance, Performance and Investment Committee
	Developing and recommending priorities to the ICB informed by place and provider collaboratives and which are aligned with the ICB's Operating Plan and ICP developed Integrated Health and Care Strategy.	Population Health and Integration Committee
	Providing assurance of strategic risk processes.	Audit and Risk Committee
	Approval of the ICB's operating structure	Chief Executive
Primary Care, Acute, Mental Health	Developing and/or recommending priorities and strategy relating to primary care services (dependent on financial authority).	Primary Care Provider Collaborative Sub-committee
	Monitoring and managing primary care outcomes as set out in the Terms of Reference for the Committee.	Primary Care Provider Collaborative Sub-committee
	Developing and/or recommending priorities and strategy relating to acute services (dependent on financial authority).	Acute Collaborative Sub-committee
	Monitoring and managing acute outcomes as set out in the Terms of Reference for the Committee.	Acute Collaborative Sub-committee
	Developing and/or recommending priorities and strategy relating to mental health, learning disability and autism services (dependent on financial authority).	Mental health, learning disability and autism

Category	ICB Decision	ICB Decision Route
		Collaborative Sub-committee
	Monitoring and managing mental health, learning disability and autism outcomes as set out in the Terms of Reference for the Committee.	Mental health, learning disability and autism Collaborative Sub-committee
Places (seven places in NEL)	Developing and/or recommending priorities and strategy relating to Place	Respective Place Sub-committee
	Monitoring and managing place outcomes as set out in the Terms of Reference for the Committee.	Respective Place Sub-committee
Annual Report and Accounts	Approval of the ICB's annual report and annual accounts.	Board
	Approval of the arrangements for discharging the ICB's statutory financial duties.	Board
	Approving a timetable for producing the annual report and account.	Audit and Risk Committee
Human Resources	Approve the terms and conditions, remuneration and travelling or other allowances for board/committee members, VSM and Executive Directors agenda for change band 9, including pensions and gratuities.	Workforce and Remuneration Committee or Non-executive Member Remuneration Committee where appropriate
	Approve the terms and conditions, remuneration and travelling or other allowances for employees, including pensions and gratuities.	Executive Management Team or within delegated limited of relevant Chief Officer.
	Approval of the arrangements for discharging the ICB's statutory duties as an employer.	Workforce and Remuneration Committee

Category	ICB Decision	ICB Decision Route
	Approve human resources policies for employees and for other persons working on behalf of the ICB.	Workforce and Remuneration Committee
Quality and Safety	Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.	Quality Safety and improvement committee
	Approve arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services, general dental, ophthalmic and community pharmacy services.	Primary Care Collaborative Sub-committee
Operational and Risk Management	Approve an operational scheme of delegation that sets out who has responsibility for operational decisions within the ICB.	Board
	Approve the ICB's arrangements for business continuity and emergency planning, preparedness and resilience.	Executive Committee
	Ensuring that the registers of interest are reviewed regularly and updated as necessary.	Board
	Approving the level of non-pay expenditure.	Board
	Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other ICBs or pooled budget arrangements under section 75 of the NHS Act 2006).	Finance, Performance and Investment Committee
	Approve the ICB's counter-fraud and security management arrangements	Audit and Risk Committee
	Approval of the ICB's risk management arrangements.	Audit and Risk Committee
	Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the ICB.	Audit and Risk Committee
	Approve the ICB's banking arrangements.	Chief Finance Officer

Category	ICB Decision	ICB Decision Route
	Responsibility for overseeing conflicts of interest.	Audit and Risk Committee (supported by Governance Team)
Information Governance	Approve the ICB's arrangements for handling complaints.	Quality Safety and Improvement Committee
	Approval of the arrangements for ensuring appropriate safekeeping and confidentiality of records and for the storage, management and transfer of information and data.	Audit and Risk Committee
	Approval of the ICB's contracts for commissioning and/or corporate support/services (for example finance provision) and securing Board approval if needed in line with scheme of delegation.	Finance, Performance and Investment Committee
	Approval of the ICB's contracts and procurement exercises, securing Board approval if needed in line with the Scheme of Reservation and Delegation.	Finance, Performance and Investment Committee
	Negotiate contracts on behalf of the ICB.	Appropriate Chief Officer
Partnership Working	Approve the arrangements for how decisions may be made on behalf of the ICB by individual members or employees of the ICB who are participating in joint arrangements.	Board
	Approve the arrangements whereby decisions may be delegated to joint committees, including those established under section 75 of the 2006 Act.	Board
Commissioning and Contracting for Clinical Services	Approval of the arrangements for discharging the ICB's statutory duties associated with its functions, including: patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.	Board
	Approve arrangements for co-ordinating the commissioning of services with other ICBs and or with local authority(ies), where appropriate.	Board
	Approval of the ICB's procurement strategy.	Finance, Performance and Investment Committee
	Approve the Working with People and Communities (Engagement and Participation) Strategy	Board

Category	ICB Decision	ICB Decision Route
Communications and Engagement	Approving arrangements for handling Freedom of Information requests.	Audit and Risk Committee
	Determining arrangements for handling Freedom of Information requests.	Chief Executive
Operational Policy	Approval of ICB operational policies in relation to health and safety and facilities management.	Executive Management Team

Category	Function	Responsibility
Implementation of specific roles as described in statutory guidance	Fulfilling the executive lead role for children and young people (0 – 25)	Chief Nursing Officer
	Fulfilling the executive lead role for children and young people with SEND	Chief Nursing Officer
	Fulfilling the executive lead role for safeguarding (all-age), including looked after children	Chief Nursing Officer
	Fulfilling the executive lead role for learning disability and autism (all-age)	Chief Medical Officer
	Fulfilling the executive lead role for down syndrome (all-age)	Chief Medical Officer
	Mental Health Lead (per constitution)	The Trust Partner member who has been appointed by the Chair, namely the Chief Executive of ELFT

Committee effectiveness surveys – key themes

What has gone well

- Effective terms of reference
- Active engagement and commitment by all
- Local residents at the heart of discussions
- Broad memberships with good relationships formed

What hasn't worked so well

- Slow to start some committees and too soon to fully evaluate
- Reports too NHS focused and not enough on children or social care
- Reports too long and technical
- Unclear lines of delegation and decision making

How could the committees be improved

- Effective forward planning
- More hybrid and face to face meetings
- More support for VCSE sector to facilitate involvement
- Shorter agenda allowing more time for meaningful consideration

North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	Board Assurance Framework
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery, Chief Participation and Place Officer
Contact for further information	Annemarie.keliris@nhs.net
Executive summary	The paper outlines progress to date and presents the updated Board Assurance Framework (BAF) which captures the highest risks to meeting the integrated care system (ICS) aims, our purpose and four priorities. The BAF has been refined and updated following review of the Chief Officer portfolio risk registers. This update also includes the detailed templates for the BAF risks. The current key risks on the BAF relate to: • Collaborative working across partners • Wider determinants of health/environment • Quality and safety of care • Delivery against control total and operating plan • Workforce • Population growth • Mutual accountability for commitments • Digital and estates • Anti-racist commitment • Being outward looking The last Audit and Risk Committee also considered the BAF and corporate risk register and welcomed the progress made.
Action required	To consider and note the updated Board Assurance Framework.
Previous reporting	ICB executive management team
Next steps/ onward reporting	• Audit and Risk Committee for assurance. • ICB and ICS executive management team to review the corporate risk register in August. • Board to receive updated BAF in September 2023
Conflicts of interest	N/A
Strategic fit	Implementing the risk strategy and policy for the ICB will support achievement of the ICB's corporate objectives through managing risks to delivery. It relates to all ICS aims: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access

	• To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The paper sets out key risks within the ICB and system in order to achieve our aims for the health and wellbeing of our population.
Impact on finance, performance and quality	Relates to achievement of our corporate objectives on these matters.
Risks	This report relates specifically to risk. The key risk in relation to this process is ensuring that we retain high levels of delegation but ensure a joined-up approach to ensure proper management and oversight of risk both locally and NEL wide.

1.0 Background

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

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

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

1.3 The BAF is constructed around the aims of the ICS:
- To improve outcomes in population health and healthcare
- To tackle inequalities in outcomes, experience and access
- To enhance productivity and value for money
- To support broader social and economic development

1.4 **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 have been developed as follows:

- Making progress on the **implementation of the ICP strategy** through working with collaboratives and places to put programmes in place against the four core priorities in the strategy, with an overarching programme for each which sets out clear

timescales and milestones and clarity on what action will happen at place and collaborative level.

- **Deliver the NHS operational planning requirements** – through this plan we will ensure the elective recovery, mental health standards trajectories set in the NEL operating plan are delivered alongside the financial plans, and that there is a joined-up approach to demand, especially urgent and emergency care, ensuing residents get the care they need.

- **Develop a system wide workforce strategy** underlined with an action plan, 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.

- Work towards **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 establish key networks to deliver on this commitment.

- To further **tackle health inequalities** by supporting our place-based partnerships to develop and implement three-year plans aligned to our ICP strategy and national best practice frameworks. This will include the launch of a new NEL Health Equity Academy to improve shared learning and joint understanding of improved data and a focus on poverty, ethnicity and specific populations.

- **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.

2.0 Risk appetite

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

3.0 Process for escalation

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

4.0 Progress to date

4.1 The BAF has been updated including the templates for all risks.

4.2 The BAF and corporate risk register were reviewed by the Audit and Risk Committee on 22 June 2023. It was reported that the governance team are continuing to work with executive team members and department risk champions to ensure the risks are described with sufficient detail with appropriate controls and mitigations.

4.3 The governance team are working with the executives to ensure the risk management policy and strategy is implemented across the organisation to enable

the Datix risk management system to be introduced during Q3 2023/24. The ICB's restructure consultation outcome and implementation will support greater clarity.

4.4 The governance team are also developing a template risk report for committees to ensure consistency across all committees in reviewing the risks they hold responsibility for.

5.0 Risks on the BAF

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

- There is a risk that ICS partners do not work together and with local people and communities in collaborative and strengths-based ways and so cannot deliver on our ICS purpose, aims and priorities. This could limit impact on improving the health and wellbeing of local people and reducing health inequalities.

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

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

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

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

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

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

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

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

- There is a risk that we are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population, due to underinvestment and limited options to secure investment. This could impact on our ability to deliver modern and safe care.

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

6.0 Next steps

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

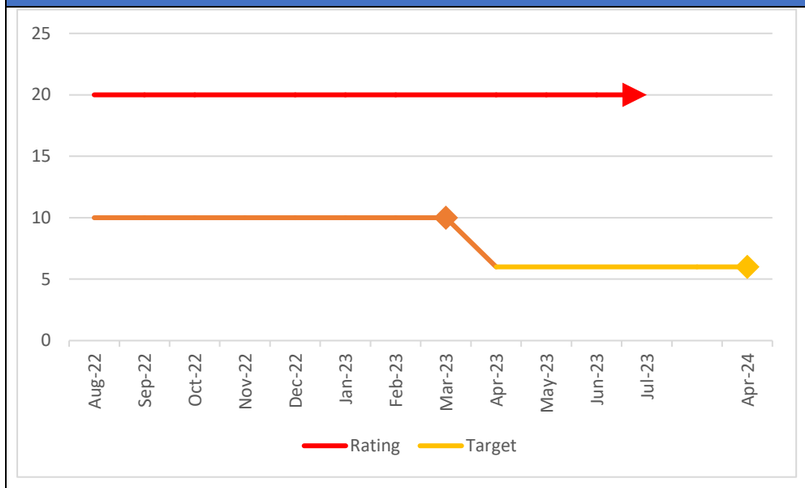
Board Assurance Framework July 2023 – Dashboard

North East London Integrated Care Board

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

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score				Target	Risk Appetite – TBC by Board	Order in BAF
				Dec/ Jan	Feb/ Mar	Apr/ May	Jun/Jul			
	turn, this could lead to poorer experience and outcomes for service users.									
To support broader social and economic development	There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.	Charlotte Pomery	Population Health and Integration Committee	16 ↔	16 ↔	16 ↔	16 ↔	8	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	4
	There is a risk that as the ICB and partners focus on our system and financial challenges, that we become more inward focused and limit our opportunities to work with and influence wider partners across London impacting our ability to improve the health and wellbeing outcomes of local people and communities.	Charlotte Pomery	Population Health and Integration Committee	N/A	N/A	16 NEW RISK TO BAF	12 ↓	8	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	10
	There is a risk that specific populations may be adversely affected if the commitment to being an anti-racist system focussed on equality, diversity and inclusion, is not met. Effects could include poorer quality of care, outcomes and employment opportunities.	Francesca Okosi	Executive Committee	N/A	N/A	15 NEW RISK TO BAF	15 ↔	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	11
	There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation; and social networks and connections.	Paul Gilluley	Population Health and Integration Committee	16 NEW RISK TO BAF	16 ↔	16 ↔	16 ↔	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	3

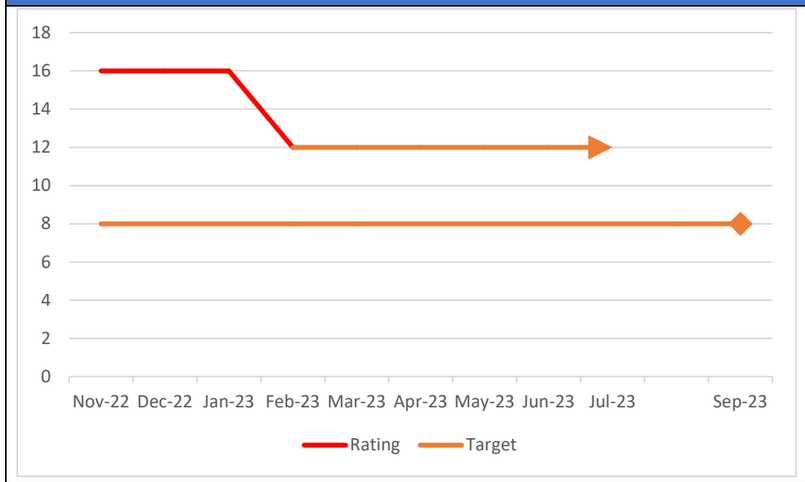
ICS Aim	**To enhance productivity and value for money**				**Risk applies to ICB**		**Risk applies to ICS**		**Risk reference**	**CFPO04 (previously CFPO01)**
					✓		✓			
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions		**Risk owner**	**Henry Black**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

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

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

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

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

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

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

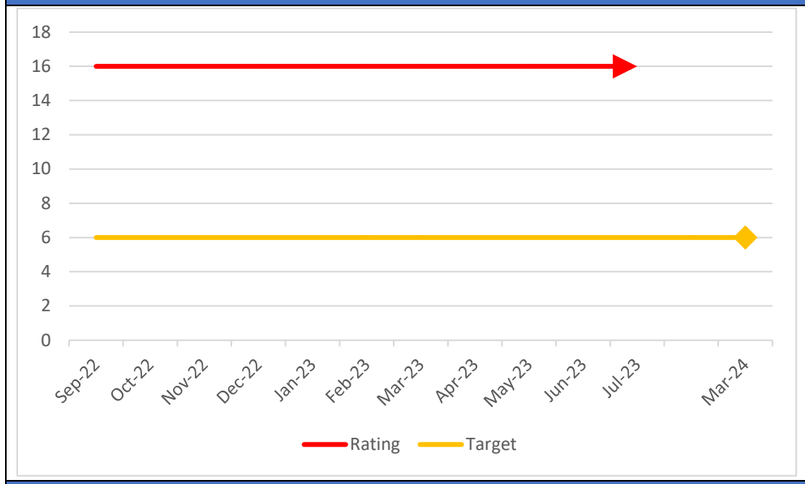
Mitigations/ actions to address the risk	Target date
Task and finish group established with broad range of involvement from ICP system to oversee development and drafting of the strategy	Complete. Jan 2023
ICP strategy to be socialised at staff meeting, and shared with senior leadership for cascading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

ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CMO (no. tbc)
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Paul Gilluley
	✓	✓	✓	✓			Responsible committee	Population Health and Integration Committee

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

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

Score history and targets



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

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

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

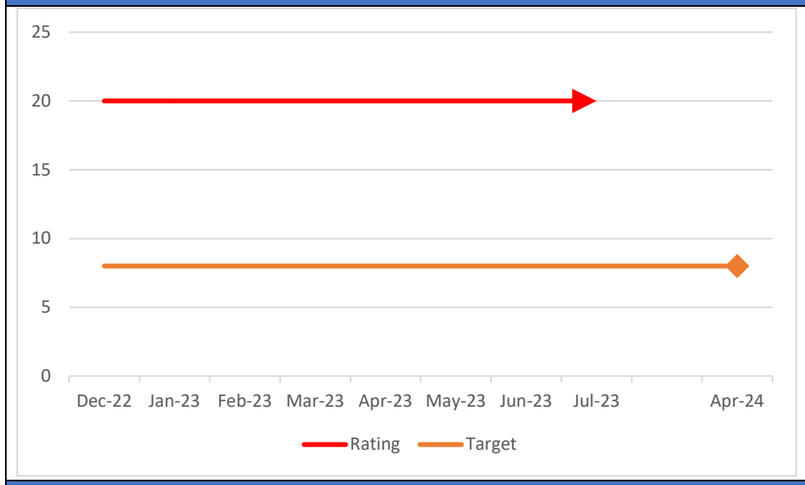
ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO11
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Charlotte Pomery
	✓	✓	✓	✓			Responsible committee	Population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

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	November 2022	Given the rapid population growth expected in north east London, there is a need to develop the infrastructure required to support people's health and wellbeing against a challenging economic backdrop.
	Target rating (LxS)	**Target date**	**Rationale**
	8	March 2024	Establishment of the ICS and ICB and all associated structures and governance are still in progress which keeps this as a risk
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	16 (4x4)	July 2023	Local forums have been established as well as a 20-year forecast programme team, however several actions are at their infancy therefore the risk score has not reduced at this stage. We are also becoming increasingly mindful of the need for an enhanced digital response to care and support models in light of population growth - this is still being worked through in the emerging Digital Strategy. The Strategy, as well as its funding and implementation, will be important mitigations in this area, and are led at Place through the same Local Infrastructure Forum.

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

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

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

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

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

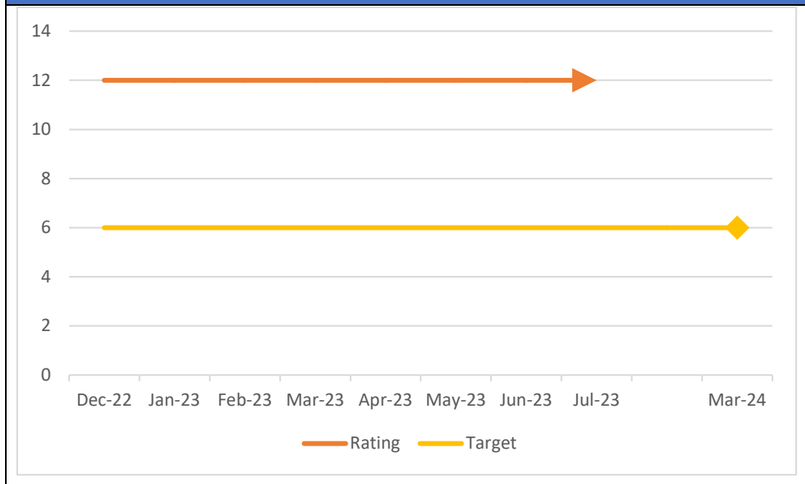
Mitigations/ actions to address the risk	Target date
Escalation discussions taking place across London Chief Nurse network and Chief Medical Officer network - also replicated across NELHCP Monthly London Clinical Executive Group	Ongoing conversations
After Action Review and Clinical Harm Review processes to be determined – done through Provider quality Meetings	Ongoing
Impact of industrial action discussion at Quality Safety and Improvement Committee (QSI) Committee – Committee will continue to review at every meeting	08/02/23 & 26/04/23 & 14/06/23 **Complete**
System programmes to support UEC improvements discussion at QSI Committee	08/02/23 **complete**
BHR UEC Place Programme Board around BHR UEC Improvement Plan and Strategy, avoidable admissions, discharge funding programmes	26/04/23 & 31/05/23 & 28/06/23 Complete

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

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

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

Score history and targets



Initial rating (LxS)	Initial date	Rationale
12 (3x4)	December 2022	Given our current service requirements and workforce pressures, that cuts across organisations, if we do not plan and deploy effectively we will not be in a position to deliver the range of services required. And, may impact on the health and well-being of our workforce.
Target rating (LxS)	**Target date**	**Rationale**
6 (2x3)	March 2024	To ensure a consistent and health and well-being offer is maintained for all staff across north east London (NEL). Plans developed and in place to allow flexible deployment and minimum employment of staff across NEL. Development of new roles that can be trained and deployed quickly to NEL utilising apprentice pathways, new roles and retention initiatives. Also, to ensure pathways and processes are in place to support and encourage local people into health and care employment.
Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
12 (3x4)	July 2023	There is work still to be completed to produce the strategy and funding is still to be secured to turn the aspirations into actions, that impact on residents' lives. Towards developing a five-year strategy delivery plan, work is ongoing and we are engaging with our staff in the ICB and across NEL ICS, including Trusts, Local Authorities, primary care, independent care providers and the voluntary sector, to include their voice and input to the strategy development, though mini-hackathons, face to face and virtual sessions, and other existing staff forums in Trusts and at Place. Also engaging with our residents at Place including all ages, under-represented groups, carers, faith leaders and refugees through focus groups and at various forums, in order to understand their needs and what will work for them as part of the strategy co-design process. Task and finish groups are being set up to translate our high-level strategic priorities into detailed short, medium, and long-term action plans, KPIs and outcome measures.

Controls and assurances
Workforce workshop held 1 November 2022.
Presentation of the outline strategy to Workforce Remuneration committee in February 2023
Further system workshop held on 24 April 2023.
High level strategic priorities discussed at ICB EMT 23 May 2023 and Executive Committee in June 2023
Presentation to Remuneration and Workforce Committee and the ICB Board on high level strategic priorities end of July 2023
Final strategy for approval and sign off at ICB EMT, Executive Committee, NEL People Board, Integrated Care Partnership Board, Workforce Remuneration Committee and ICB Board by end November 2023

Mitigations/ actions to address the risk	Target date
Initial engagement with Local Authorities, providers voluntary sector since October 2022	Completed – engagement continues as required
High level outline drafted for overall ICS strategy.	Completed – November 2022
Further engagement with all system partners on further shaping and developing the strategy	Completed - January 2023. Engagement will continue through to mid-April 2023
High level system people and workforce strategic priorities presented to the ICB Executive Management Team in June 2023	Complete.
Confirmation of funding to continue the Keeping Well offer for staff into 2023/24	Complete.
High-level system people and workforce strategic priorities to be signed off via ICB Board by July 2023	July 2023
Set up a task and finish group to develop and agree a minimal employment offer and flexible deployment of staff	September 2023
Ensure full utilisation of the levy and infrastructure to support learning in the workplace. Building cohorts of up skilled staff incrementally	January 2024
Through existing health and care recruitment hubs a commitment to offer 900 posts to local residents - incrementally up to 2024 funded by the GLA	January 2023 and ongoing

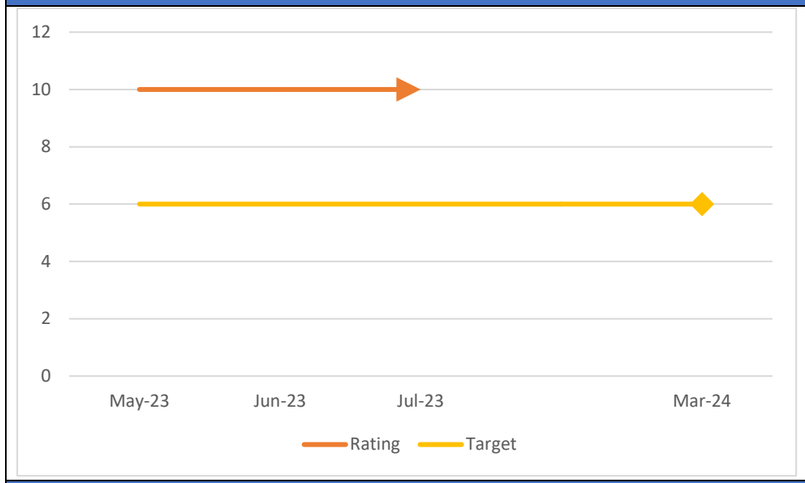
ICS Aim	To tackle inequalities in outcomes, experience and access							Risk applies to ICB	Risk applies to ICS	Risk reference	CNO (no. tbc)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Diane Jones
	✓		✓		✓		✓			Responsible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

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

Controls and assurances
Incident Management calls across the ICS have been implemented.
System Oversight Command Group stood up across NELHCP.
The NEL System People Board are in place
Recruitment across Clinical Leadership roles to support improvement programmes to address risk i.e. Director of Allied Health Professionals role
International recruitment campaigns in place across all NEL Providers i.e. NELFT programme in Africa
Nursing and Midwifery Workforce Expansion Board – regional group to deliver against the Government promise to increase nursing and midwifery numbers
National CNO strategy to be launched in Sept followed by an implementation plan – NEL CNO Group priority is workforce
National Long term workforce plan published – NHS NEL looking at how to respond to deliverables

Mitigations/ actions to address the risk	Target date
Escalation discussions taking place across London Chief Nurse network and Chief Medical Officer network - also replicated across NELHCP	Monthly
Consideration to be given to areas of clinical activity that could be stood down if needed. – ongoing conversations through CAG and Incident Management Meeting	Ongoing
Review the possibility of requesting additional clinical support across the system and possible redirection of clinical support – done via submissions that come into Incident Management Meeting	Daily
Nursing retention discussions ongoing across NEL and will be part of NEL response to national CNO Strategy and Implementation Plan	October 2023
Impact of industrial action discussion at QSI Committee	08/02/23 & 26/04/23 & 14/06/23 **Complete**
System programmes to support UEC improvements discussion at QSI Committee	08/02/23 **complete**

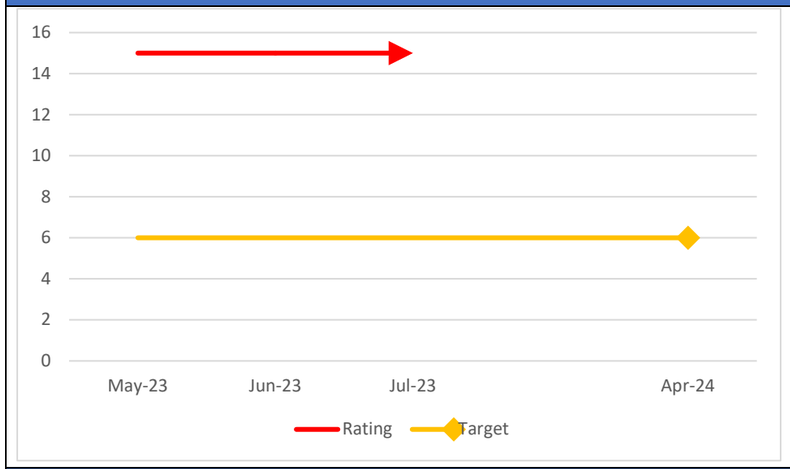
ICS Aim	To enhance productivity and value for money				Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO02
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Johanna Moss
	✓	✓	✓	✓			Responsible committee	Finance, Performance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

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	10 (2x5)	May 2023	NEL-wide Infrastructure Strategy required by NHS England before December 2023 (TBC). Options and priority areas for investment need to be reviewed to enable better future planning of investment and spend.
	Target rating (LxS)	**Target date**	**Rationale**
	6 (2x3)	March 2024	As work on the strategy starts, this will drive down the severity score as mitigations will be identified.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	10 (2x5)	July 2023	A meeting with Julian Kelly has been set up for October 2023, where the ICS has the opportunity to present a case seeking additional National investment to support the current and future growth across NEL. A system wide planning group has been established to co-ordinate and oversee the development of the case for additional investment.

Controls and assurances
Internal ICB processes to deliver greater transparency on future spend.
Implementation of ICB and ICS governance structures which include various committees and sub-committees which are held on monthly or bi-monthly basis with ICS partners.

Mitigations/ actions to address the risk	Target date
Establishment of Local Infrastructure Forums.	March 2024
Development of long-term Strategic Infrastructure Approach.	March 2024
Options and priority areas for investment reviewed to enable better future planning of investment and spend.	March 2024
Meeting with Julian Kelly to present a case seeking additional National investment to support the current and future growth across NEL. A System wide planning group has been established to co-ordinate and oversee the development of the case for additional investment.	October 2023

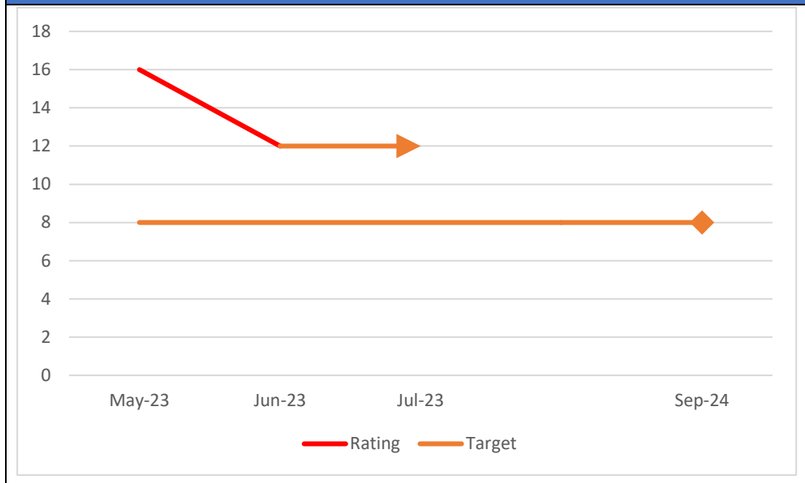
ICS Aim	To enhance productivity and value for money				Risk applies to ICB	Risk applies to ICS	Risk reference	CFPO14/ CFPO15
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Henry Black
	✓	✓	✓	✓			Responsible committee	Finance,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

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

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

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

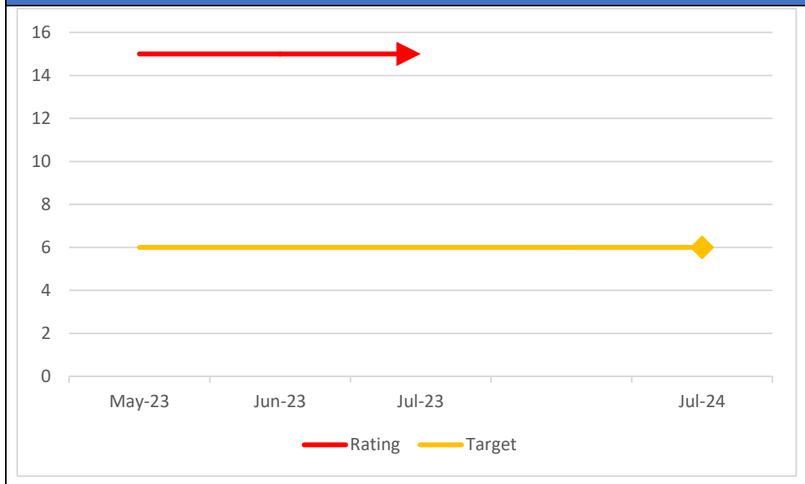
ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO (no.tbc)
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Charlotte Pomery
	✓	✓	✓	✓			Responsible committee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

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	May 2023	The system is facing significant financial challenges and the ICB is going through a restructure, meaning that learning from regional and national can be challenging and time consuming.
	Target rating (LxS)	**Target date**	**Rationale**
	8 (4x2)	September 2024	It is anticipated that over a year will be required and able to fully mitigate this risk - allows significant lead in time following the organisational restructure, as well as understanding the implications of the Hewitt review and wider policy context.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	12 (3x4)	July 2023	We continue to participate actively in national, regional and indeed cross north east London forums to share and learn from best practice. We have built communities of practice in a number of areas and are represented well on leadership forums across sectors including for example community work, care services and co-production. We are part of London forums on a range of topics and actively learning from each other.

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

Mitigations/ actions to address the risk	Target date
Involvement in research and pilot initiatives.	September 24
System leaders participating in national and regional groups.	September 24
The ICB's Managing Director of Primary Care is chair of the Primary Care PODS Group.	Complete.
Participating in national, regional and local forums to share and learn best practice	Continuing
Communities of practice have been built in a number of areas, including community work, care services and co-production	Complete and continuing

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

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**15 (3x5)**	May 2023	This is an initial rating which could have a high severity impact. Work is underway to work through the model to determine an approach.
	Target rating (LxS)	**Target date**	**Rationale**
	6 (2x3)	July 2024	There are several actions to work through to mitigate the risk to the desired tolerance, therefore it is anticipated that over a year will be required to reach this threshold.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	15 (3x5)	July 2023	There are not at this specific time resources allocated to carry out this work but posts will be recruited to as we roll out the new structure. Work is planned to start from early September to take stock of all our staff and what issues there are through an audit of key factors to start to develop benchmarks. The bespoke Equality, Diversity and Inclusion (ED&I) diagnostic audit tool, based on 9 key factors, (including leadership, vision, culture and behaviours, data, policy and process, recruitment and talent management), will be rolled out to all staff to enable a deep dive on specific issues relevant to the ICB. This work will highlight critical areas for the ICB to focus on.

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

Mitigations/ actions to address the risk	Target date
Strengthening of staff networks to support protected characteristics.	July 2024
Ensuring coproduction reflects local diverse populations.	July 2024
Maintaining our commitment to the Health Inequalities funding which can affect employment opportunities.	July 2024
Co-creating and implementing the Equality, Diversity and Inclusion Strategy.	July 2024
Ensuring that our core communications include community languages.	July 2024
Implement ED&I rapid diagnostic audit tool for a deep dive and, to highlight specific critical areas for the ICB to focus on.	December 2023

SUPPORTING INFORMATION

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

Committees of the Integrated Care Board:

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

Aims of the Integrated Care System:

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

Risk grading matrix

Risk Category	
	Severe
	High
	Medium
	Low

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

NHS
North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	Executive Committee exception report
Author	Katie McDonald, Governance Manager
Presented by	Zina Etheridge, Chief Executive Officer
Contact for further information	Katie McDonald, Governance Manager katie.mcdonald3@nhs.net
Executive summary	This report provides a summary of the key items from the meetings of the Executive Committee held on 13 June 2023 and 13 July 2023. The key items detailed in the report include: • A call for evidence on the major conditions strategy • The strategic priorities for a system-wide people and workforce strategy • Delegation of primary care complaints from NHS England • New NHS guidance regarding patient choice • Same Day Access Hubs business case
Action required	Note
Previous reporting	None – this is an exception report from the meetings held in June and July 2023.
Next steps/ onward reporting	The committee meets again on 7 September 2023 and a regular exception report will be presented to the Board.
Conflicts of interest	There are no conflicts of interest identified in relation to this report.
Strategic fit	• To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The committee has an overall focus on addressing inequalities, reducing variation and improving equity for all the people of north east London while ensuring participation and co-production is central to our collective approach.
Impact on finance, performance and quality	The committee is established to provide executive oversight of the ICS system budget and financial delegations to ensure delivery of system control total and financial improvement trajectory. Provide executive oversight of system finance and associated risks. Ensure opportunities for bidding for transformational funding are maximised and provide oversight of bids. Approve matters in line with the scheme of reservation and delegation.

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

Purpose of the report

1.1 This report provides a summary of the key items from the meetings of the Executive Committee held on 13 June 2023 and 13 July 2023.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 In June the committee were asked to contribute to the call for evidence for the Major Conditions Strategy. The strategy focusses on what can be delivered over the next five years in England combining commitments made on: mental health, cancer, dementia, cardiovascular disease, chronic respiratory diseases, musculoskeletal conditions and health disparities into a single strategy. It will also align with the government's ambitious life sciences missions and take a life-course approach to improving health outcomes. On 17 May 2023 a call for evidence for the Major Conditions Strategy was launched. The call for evidence will build on the insights from recent evidence calls in respect of cancer and mental health during 2022. The mental health call for evidence in 2022 was aimed at informing a new 10-year mental health and wellbeing plan. However, in January 2023 the government announced it will instead incorporate mental health into the major conditions strategy to ensure mental health conditions are considered alongside physical health conditions in a joined-up approach. Committee members shared concerns that this will result in less of a focus on mental health and there was a preference for a standalone plan.

2.2 The committee received a report which outlined the high-level strategic priorities for North East London's People and Workforce Strategy. The strategy aims to address critical workforce supply issues across our health and care partnership, aimed at developing an integrated 'one workforce' model to support the delivery of the four system priorities of the Integrated Care Strategy. The seven high-level strategic priorities were endorsed by the committee and have been recommended for ICB board approval at today's meeting.

2.3. Members received an update report explaining that the delegation of primary care complaints from NHS England has been taken forward and in London each ICB will manage its primary care complaints in an integrated model. This will enable ICBs to manage complaints for their local communities across their systems and better utilise the intelligence and learning gained, to further develop service delivery strategies and improve the ICB's patient facing policies and procedures, so improving the patient experience. North East London ICB became responsible for the management of primary care complaints (covering general practice, pharmacy, optometry and dental services) on 1 April 2023 and became operationally responsible on 1 July 2023 when the staff resource to take on this additional work was transferred over to ICBs and to NHS North East London specifically.

2.4 The committee received a report advising that NHS England has restated their commitment to Patient Choice in a letter to Integrated Care Systems on 25 May 2023. This letter outlined out a set of actions and activities expected of ICBs, primary and secondary care to improve patient choice for elective care. Primary care and

clinical assessment services are expected to offer patients a choice of a minimum of five providers, which can include independent sector and out of area. Referrers are asked to actively encourage patients to manage their own referral on eRS or the NHS app. The Covid recovery programme had meant that there were restrictions to referrals in place, however the Planned Care Board have now agreed to lift these. The lifting of restrictions will be timed across the system appropriately in phases and it is anticipated that all restrictions will be removed by the end of August 2023. ICBs have been asked to ensure that patient transport costs are not prohibitive to patients exercising choice and are required to identify a Senior Responsible Officer for patient choice. Members of the committee recommended that an equality impact assessment is conducted to demonstrate whether this could exacerbate any health inequalities as it is possible that residents who are more economically deprived will wait longer for treatment as they cannot afford to travel further than their local hospital or treatment centre.

2.5 On 13 July an extraordinary committee meeting was held in order to consider the business case for same day access hubs. Additional information was requested by committee members; therefore, the proposal was not agreed at this meeting however will be reconsidered when the additional information is provided.

3.0 Risks and mitigations

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

North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	Audit and Risk committee exception report
Author	Cha Patel, Audit & Risk Committee Chair
Presented by	Cha Patel, Audit & Risk committee Chair
Contact for further information	anna.mcdonald@nhs.net
Executive summary	This report provides a summary of the key items from the meeting held on 22 June 2023.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in May 2023.
Next steps/ onward reporting	The committee meets again on 30 August 2023 and a further report will be presented to the board.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The remit of the committee is to contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management, internal control processes and arrangements to manage conflicts of interest within the ICB.
Impact on finance, performance and quality	N/A
Risks	The Committee will be driven by the organisation's objectives and the associated risks and its duties will be governed by the Terms of Reference. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

1.0 Purpose of the report

1.1 This report provides a summary of the key items from the Audit and Risk Committee meeting held on 22 June 2023.

1.2 The board is asked to note this report.

2.0 Key messages

2.1 Following a robust review undertaken during April and May, the committee received final drafts of the annual reports and accounts for the legacy Clinical Commissioning Group (CCG) Q1 and the ICB Q2 - Q4 for final comment and approval. The outcome

of our External Auditor's audit on the financial statements and the Head of Internal Audit Opinion were also presented. No significant issues were identified and the committee recommended approval to the ICB board.

2.2 The committee received assurance that there are no areas of concern in regard to the transfer of dental, optometry and pharmacy services (PODs) to the ICB and were pleased to hear that everything is on schedule for the transfer to take place on 1 July 2023.

2.3 Committee members were presented with the draft digital strategy for review and comment. Members welcomed the progress made on the system-wide draft digital strategy which is being produced with system partners and is aimed at all the providers across the north east London system including social care.

2.4 An update on the Data Security and Protection Toolkit submission was received and members noted a summary of the related policies that have been updated. Our Internal Auditor, RSM, has audited the self-assessment and advised the committee that they are satisfied with the content.

2.5 The committee received the 2023/24 work plans for Internal Audit and Local Counter Fraud Services for comment and approval.

3.0 Risks

3.1 Purchase Order performance is currently at 50% of the mandated 100% level required by April 2024.

3.2 The need for staff to remain up to date with their training is key to avoiding triggering the most common digital risks.

3.3 Continuing Health Care will need continuing focus.

3.4 Prescribing costs are adding additional pressures to an already challenging year for achieving financial targets required by NHS England.

Author: Cha Patel
July 2023

North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	Workforce and Remuneration committee exception report
Author	Anna McDonald, Senior Governance Manager
Presented by	Marie Gabriel, ICS Chair/ Vice Chair of the Workforce and Remuneration Committee
Contact for further information	anna.mcdonald@nhs.net
Executive summary	This report provides an overview of the item discussed at the committee meeting held on 14 July 2023.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in May 2023.
Next steps/ onward reporting	The committee meets again on 25 July 2023 and an exception report will be presented to the board going forward.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	Employment and workforce – to work together to create meaningful work opportunities and employment for people in north east London now and in the future.
Impact on local people, health inequalities and sustainability	The Committee will receive assurance on the ICB's Employment Flagship Priority, ensuring that we utilise the ICB's ability to provide meaningful and positive employment opportunities for local residents.
Impact on finance, performance and quality	The Committee and all of its members are bound by the ICB's Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB.
Risks	The Committee will be driven by the organisation's objectives and the associated risks and its duties will be governed by the Terms of Reference. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

1.0 Purpose of the report

1.1 The purpose of this report is to provide an overview of the agenda item discussed at the committee meeting held on 14 July 2023.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 On 14 July the committee approved the new operating model for the ICB and the proposals to reduce the running costs allowance. A summary of the report detail and discussion is provided below.

2.2 The report outlined the steps that have been taken to develop a new operating model for NHS North East London ICB. The restructure has been designed to enable us to meet our new objectives as an ICB and create a refreshed organisation which is not an amalgamation of predecessor structures. Significant resource has been retained at place, but now with commonality across the boroughs and there is a clear focus on supporting residents to start well, live well and age well. Designing the new model also meant that we needed to include the arrangements to move towards the 30% Running Cost Allowance (RCA) reduction following NHS England's direction to ICBs, which could only be achieved by re-thinking the way that the organisation and system operates.

2.3 The committee was provided with assurances in relation to the staff consultation process and it was explained that the consultation allowed for comprehensive staff engagement throughout and that staff also have access to tools to support them through this process. Senior leaders have worked in partnership with the recognised trade unions and met formally during the consultation process. The trade unions were able to represent the views of their members and identify risks and issues which were acted upon.

2.4 During the consultation process it was agreed to delay further work on key areas of the Chief Nursing department to ensure the new operating model met its statutory responsibilities and enabled the ICB to exercise its responsibilities for oversight of the quality of patient care across the integrated care system in North East London. This will be revisited as part of phase three of the change programme which will also include some areas of work from other departments, and the outcome of that work will be reported back to the Board in the autumn.

2.5 The committee received a copy of the Equality Impact Assessment (EIA) after the meeting for assurance and were informed that EIAs been undertaken at each stage of the reorganisation to monitor and mitigate any adverse impacts from the proposed changes. In addition to this, the ICB has taken steps to ensure the process is fair and transparent so that all staff have an equal opportunity and that bias is removed from the process, which include diverse interview and appeals panels as well as de-bias training for panel members.

2.6 The committee was advised that the proposed structure has been costed, including pay awards, and the remainder of the 30% RCA reduction needed will be pursued as we make further changes.

2.7 Following the committee's approval, the implementation process started week commencing 17 July 2023.

2.8 The Workforce and Remuneration Committee will continue to report updates regarding the ICB operating model to the Board.

North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	Quality, Safety and Improvement (QSI) committee exception report
Author	Dotun Adepoju, Senior Governance Manager
Presented by	Imelda Redmond, Non-Executive Director
Contact for further information	dotun.adepoju@nhs.net
Executive summary	This report provides a summary of the key items from the meeting held on 14 June 2023.
Action required	The board is asked to note the report.
Previous reporting	The topics covered in this report have previously been considered and scrutinised by the QSI committee.
Next steps/ onward reporting	• Plans are in place to address the BHRUT CQC findings a through the BHRUT CQC Improvement Plan • Continue the safeguarding support work with regards to the Contingency Hotels across NEL • Continued support for Partnership of East London Co-operatives (PELC) through the Enhanced Surveillance approach to drive organisational improvements and change identified by the CQC
Conflicts of interest	There are no known conflicts of interest
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	Each topic is an area of service delivery which aims to improve the quality of care for local people through recognising opportunities for quality improvement.
Impact on finance, performance and quality	All the topics highlight areas for further quality improvements, particularly where joint working at place is beneficial for local delivery.
Risks	Of the topics discussed by QSI the greatest risks noted are those related to tackling inequalities in outcomes, experience and access. The risk related to the CHC Digital Systems procurement process has been paused. One of the mitigation actions is to develop a funding envelope for the new system including mobilisation costs.

1. Purpose of the report

1.1. This report provides the Board with an overview of the items discussed at the QSI committee held on 14 June 2023 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. There were rich discussions reflecting the strategic importance of the papers presented to the work of all partners.

1.2. The Board is asked to note this report.

2. Key messages

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

2.2. The Committee received a report on Patient Safety Incident Response Framework (PSIRF). In 2019, the NHS Patient Safety Strategy was published, it seeks to embed transformational changes in the way we understand and address issues of patient safety within our organisations.

2.3. The Committee was given an update on the NEL Urgent and Emergency Care (UEC) programme. Urgent and emergency care is under significant pressure across the country. These pressures are also felt within the north east London footprint by our providers, particularly in the acute provider setting.

2.4. A report on Quality horizon scanning was presented to the Committee. It provided an update on the planned regulatory activity that will assess quality within and across Integrated Care Boards.

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

- System issues such as the work undertaken by the ICB safeguarding teams with regards to Contingency Hotels to ensure safeguarding pathways are clear and how the work is being taken forward through place-based refugee and asylum seeker task and finish groups; progress being made by BHRUT with regards to their CQC Improvement Plan.
- Quality at Place reported as system issues across Place covering acute, community, mental health, primary care and social care.
- Individual Funding Requests (IFR) and how they can support transformation discussions going forward based on themes and trends arising from IFRs
- Adult Safeguarding and Children Safeguarding
- Maternity – the Committee sought clarity on the strategic risks regarding maternity and what programmes of work are in place to mitigate and drive improvements in maternity services across NEL and requested a further update at a future meeting.
- Infection prevention and control (IPC)

3. Risks and Mitigations

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

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

Dotun Adepoju, 3 July 2023

North East London
Integrated Care Board

NHS North East London ICB board

26 July 2023

Title of report	Finance, Performance and Investment Committee exception report
Author	Matthew Knell, Senior Governance Manager
Presented by	Henry Black, Chief Finance and Performance Officer Kash Pandya, Associate Non-Executive Member / Chair of the Finance, Performance and Investment Committee
Contact for further information	matthew.knell@nhs.net
Executive position summary	The Finance, Performance and Investment Committee (FPIC) last met on Monday 26 June 2023, to discuss the following business: • Month 12, 2022-23 Performance Overview • Month 2, 2023-24 Finance Report • Risk Register • Recommendations from the Business Case Assurance Group: Same day access hubs • Recommendations from Procurement Group: Community Diagnostics & Newham Musculoskeletal • Deep Dive: Prescribing • Updates from Committee sub groups: Primary Care Contracting Sub-Committee
Action required	The Board is asked to note the report.
Previous reporting	None – this is an exception report from the June 2023 Committee meeting.
Next steps/ onward reporting	The Committee next meets on Monday 4 September 2023 and a regular exception report will be presented to the Board along with any approved minutes.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	The ICS aims this report aligns with are: • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	One of the Committee's responsibilities is to review and approve allocation of contingency funding which is to include transformation, productivity and to aid the reduction of health inequalities for the residents of North East London.
Impact on finance, performance and quality	The Committee is established to provide assurance and oversight to the Board on the robustness of the short- and long-

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

1.0 Introduction / Context / Background / Purpose of the report

1.1 The last meeting of the Finance, Performance and Investment Committee (FPIC) took place on Monday 26 June 2023 and this exception report outlines the key messages, recommendations, decisions and actions taken by FPIC members in accordance with its terms of reference.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The Committee considered a performance report on delivery against targets across North East London (NEL). This highlighted that the system had been placed by NHS England (NHSE) in tier one remedial measures for its urgent and emergency care services and tier two for its cancer services. The ICB and NHSE are now developing plans with providers to improve performance across these services. The Committee remained concerned about the delays with diagnostics and requested more information on the effectiveness of remedial measures put in place to improve performance, as well as, data on performance on community services.

2.2 Members received the first finance report of 2023/24, based on data from month two, which recognised a variance to plan of £25.7m across the ICS, including a year to date variance to plan of £7m within the ICB. This was largely driven by pressures relating to inflation, run rate pressures such as ICB prescribing and Continuing Health Care (CHC) expenditure and the under delivery of efficiency schemes. Members considered the adverse financial trends and requested more detailed information and deep dives at a future meeting on CHC and the use of agency staff.

2.3 The Business Case Assurance Group (BCAG) recommended that FPIC support the Same Day GPs Access Hubs business case while a new NEL wide delivery model for these services was developed. The FPIC supported the request for £22,881,021 (£7,627,007 per annum) over three years from October 2023 with an annual break clause. This business case will now be considered by the Executive Committee as the proposed spend falls outside the remit of FPIC. FPIC asked to be periodically updated on progress of this transformation work in terms of financial and performance aspects and recommended that the Population Health Integration Committee (PHIC) might wish to consider monitoring the transformative elements of the service and its potential implications for Primary Care Networks (PCNs).

2.4 The Procurement Group had made two recommendations to the FPIC:

2.4.1 The Committee approved the outcome of a procurement exercise to recommission GP Direct Access Community Diagnostics Services in Tower Hamlets, Newham, Waltham Forest, Barking, Havering and Redbridge. Members recognised that this specific contract was essentially a 'call off' contract, where the service formed part of the menu of choices available to local people and provided extra capacity in the area while NEL wide transformation plans were being developed.

2.4.2 The Committee agreed a recommendation for a single tender waiver for MSK services totalling £19.9m for a 20 month period for the Newham element of this service, from August 2023 to March 2025 (with a break clause) to enable alignment with the NEL-wide Musculoskeletal Transformation Programme.

2.5 Members held an extended, 'deep dive' discussion on prescribing and medicines management matters and were briefed on some areas of work, including an exploration of the drivers behind the 2022/23 prescribing overspend and a summary of lessons learnt. The meeting was also briefed on the forecast position for 2023/24, and the mitigations that have been put in place to support this year's delivery of cost efficiencies and how budget forecasting and delivery of cost efficiencies will be performance monitored and measured, along with governance arrangements to escalate any risks/issues that materialise through the year.

3.0 Risks and mitigations

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

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

Author: Matthew Knell, Senior Governance Manager
Date: 13/07/2023

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NHS North East London ICB board

26 July 2023

Title of report	Population Health and Integration committee exception report
Author	Katie McDonald, Governance Manager
Presented by	Marie Gabriel, ICS Chair/ Chair of the Population Health and Integration Committee
Contact for further information	katie.mcdonald3@nhs.net
Executive summary	This report provides a summary of the key items from the meeting held on 21 June 2023.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in May 2023.
Next steps/ onward reporting	The committee meets again on 5 September 2023 and a further report will be presented to the board.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access
Impact on local people, health inequalities and sustainability	The remit of the committee is to identify opportunities to support and improve effective population health management and integration of health and care services at place and within collaboratives for the residents of north east London.
Impact on finance, performance and quality	N/A
Risks	The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

1.0 Purpose of the report

1.1 The Population Health and Integration Committee (the Committee) was held on 21 June 2023 and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference. There were rich discussions reflecting the strategic importance of the papers presented to the work of all partners.

1.2 The board is asked to note this report.

2.0 Key messages

2.1 The Committee received a report which outlined the responses provided by members in response to the committee effectiveness survey. The annual review of the committee's effectiveness enabled the opportunity to reflect on the significance of partnership working over the last year whilst also recognising that there are areas which can be improved upon and enhanced. One of the key areas for improvement over the next year will be to ensure that the information flow between all committees and sub-committees is efficient and of value. An overall summary of all the ICB committees' effectiveness is provided within the governance handbook report at today's Board meeting.

2.2 Members reviewed the three Board Assurance Framework (BAF) risks which the committee holds responsibility for and relate to:

- Being outward looking
- Population growth
- Wider determinants of health/environment

The Committee discussed the importance of being honest and transparent about the risks and associated issues in order to identify meaningful and effective mitigations, as well the need to focus on mitigating circumstances outside of the partnership's control. It was agreed that, going forward, the committee would review one of the risks at each of its meetings, in turn, in order to review in greater depth.

2.3 The committee received reports from each of its sub-committees which had a theme of 'working through a health inequalities lens'. The reports highlighted the range of work underway across north east London to address the significant health inequalities experienced by the population, including the alignment of strategic priorities and outcomes with links between Health and Wellbeing Strategies, Core 20 Plus 5 and the Integrated Care Partnership Strategy.

2.4 The reports also underlined the need for a range of enablers to be in place to support the increasing focus on integration, including estates infrastructure across all partner, data and insights with granular detail on specific populations and having the ability to take opportunities when they arise. Another commonality across the sub-committees was that, whilst the Health Inequalities Funding is very much welcomed, it may not be sufficient as we seek to embed health inequalities approaches across all our work and recognise that there is inequity across some of the core budgets directly affecting this work (Public Health Grants for example).

2.5 The Committee welcomed a deep dive presentation from representatives of the Community Health Collaborative sub-committee regarding the work they are doing to address health inequalities through community services. The collaborative has had a focus on delivering virtual wards which will enable residents to receive care at home or closer to home and therefore reduce unnecessary hospital attendances; improving experiences and outcomes for residents. A community dashboard is being developed to help better understand data in north east London in order to reduce variation. The dashboard currently includes Frailty, Urgent Community Response (UCR) and End of Life due to the availability of data sets. Further collaboration work is happening to ensure stakeholders can utilise this data in decision making, developing business cases or supporting changes to pathways to reduce variation across our geographical areas.

2.6 The sub-committee has been developing an outcomes framework to:

- Identify standards that each resident can expect: common standards on access, uptake and expectations across NEL, ensuring that these can be linked to different population needs across the boroughs
- Identify outcomes associated with broad principles of community-based care
- Capture the impact of services on patients (how to measure value-based care)
- Set out what is already in place and identify gaps
- Identify areas of best practice – share, collaborate and build on this
- Include NHS operating plan targets: Ageing Well, Virtual Wards etc.
- Align measures, data collection and reporting. Enable the tracking of the resident's journey across different services.

3.0 Risks and mitigations

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

Author: Katie McDonald, Governance Manager
Date: 10.07.2023

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Integrated Care Board Forward Plan

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