North East London
Integrated Care Board

NHS North East London ICB board

29 November 2023, 1.30pm – 4.10pm; Tower Hamlets Town Hall

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 27 September 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**	2.00			
3.1.	Chair's report		Chair	Attached	Note
3.2.	Chief executive officer's report		ZE	Attached	Note
4.0	**Strategy**	2.10			
4.1.	Our approach to system recovery		JM	Attached	Note/ assure
4.2.	Supporting Equity and Sustainability in North East London		ZE	Attached	Note
5.0	**Quality**	2.30			
5.1.	Deep dive: cancer		FOd/ AW	Attached	Note
6.0	**Finance and performance**	2.50			
6.1.	Financial overview		SC	Attached	Note
6.2.	Performance report		SC	Attached	Note
7.0	**Governance**	3.10			
7.1.	Governance update		CPo	Attached	Approve
7.2.	Board Assurance Framework		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		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: 31 January 2024					

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 23/10/2023

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 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	Igloo Consultants Limited	Director of family owned consultancy business	2022-12-12		
Diane Herbert	Non-Executive Member	ICB Board ICB Quality, Safety & Improvement Committee ICB Workforce & Remuneration 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
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

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 Paul Francis Gilluley	Chief Medical Officer	Acute Provider Collaborative Joint Committee Clinical Advisory Group ICB Board 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		
			Non-Financial Personal Interest	National Opera Studio	Member	2023-08-01		
Henry Black	Chief Finance and Performance Officer	Acute Provider Collaborative Joint Committee 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		
Dr Jagan John	Primary Care ICB Board representative	ICB Board 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	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

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
Johanna Moss	Chief strategy and transformation officer	Community Health Collaborative sub-committee 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 Primary care contracts subcommittee	Non-Financial Professional Interest	UCL Global Business School for Health	Health Executive in Residence	2022-09-01		
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 Race and Health Observatory, (paid). The Race and Health Observatory are now considering the potential to enter into contracts with NHS organisations to support their work to tackle racial and ethnic health inequalities,	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	UK Health Security Agency	Associate NED, (paid), UKHSA works with health and care organizations to ensure health security for the UK population	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
Zina Etheridge	Chief Executive Officer of the Integrated Care Board for north east London	Acute Provider Collaborative Joint Committee 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 NEM Remuneration 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 23/10/2023

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	Acute Provider Collaborative Joint Committee ICB Board ICS Executive Committee	Indicated No Conflicts To Declare.
Manisha Modhvadia	Healthwatch	Barking & Dagenham Partnership Board ICB Board ICP Committee	Indicated No Conflicts To Declare.
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	Indicated No Conflicts To Declare.

NHS
North East London
Integrated Care Board

Minutes of the NHS North East London ICB board

27 September 2023, 1.30pm – 4.00pm, Microsoft Teams

Members:	
Marie Gabriel (MG)	Chair, NHS North East London and North East London Health and Care Partnership
Zina Etheridge (ZE)	Chief executive officer, NHS North East London
Henry Black (HB)	Chief finance and performance officer, NHS North East London
Dr Paul Gilluley (PG)	Chief medical officer, NHS North East London
Diane Jones (DJ)	Chief nursing officer, NHS North East London
Diane Herbert (DH)	Non-executive member, NHS North East London
Imelda Redmond (IR)	Non-executive member, NHS North East London
Paul Calaminus (PC)	NHS trust partner member
Shane DeGaris (SD)	NHS trust partner member
Cllr Maureen Worby (MW)	Local authority partner member
Caroline Rouse (CR)	VCSE partner member
Dr Jagan John (JJ)	Primary care partner member
Dr Mark Rickets (MR)	Primary care partner member
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
Kash Pandya (KP)	Associate non-executive member
Sarah See (SS)	Managing director of primary care, NHS North East London
Dr Ben Molyneux (BM)	Associate medical director of primary care, NHS North East London
Tracey Denovan (TD)	Resident
Suma Kuriakose (SK)	Resident representative, Barking, Havering and Redbridge University Hospitals Trust
Anne-Marie Keliris (AMK)	Head of governance, NHS North East London
Katie McDonald (KMc)	Governance manager, NHS North East London
Apologies:	
Cha Patel (CPa)	Non-executive member, NHS North East London
Andrew Blake-Herbert (ABH)	Local authority executive participant
Manisha Modhvadia (MM)	Healthwatch 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. The Chair advised members that Mayor Philip Glanville has stepped down from his role at London Borough of Hackney and therefore is no longer a member of the ICB Board. The Board thanked Mayor Glanville for his dedication and contributions and

	the Chair advised that local authority leaders are working to propose a nomination for the local authority partner member vacancy on the Board. The Chair advised people of 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. Paul Calaminus advised that his declaration is being amended to reflect his new role as Chief Executive of NELFT. 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 meetings held on 26 July 2023 were agreed as a correct record.
1.3	Matters arising
	There were no matters arising.
1.4	Actions log
	4.2 Financial strategy – The Chair requested that a date is set for the workshop. 6.2 Performance report (after action reviews from industrial action) – FO advised that a whole system after action review would be taking place which will be reported back to the Board. **ACTION:** FO to present an update on the Integrated Care System (ICS) after action review of the industrial action at a future meeting. The ICB board noted the actions taken since the last meeting.
2.0	**Resident story**
	TD provided members with her story as a resident of north east London which focussed on her experience with general practice and community health centres. Key points included: • TD received a misdiagnosis of a life limiting condition which caused distress to herself and her family. At the time of diagnosis, information provided by the clinician was limited and it took an extended amount of time for the GP practice to be informed of the initial diagnosis which led to a delay in receiving treatment. • A member of general practice staff provided an incorrect demonstration of how to use an inhaler. The member of staff also behaved in an unprofessional manner which led to a formal complaint being made, however no feedback was provided by the practice. • When the correct diagnosis was reached, TD received pulmonary rehabilitation at a local community health centre which has significantly improved her physical and mental health.

	SK presented the Board with testimonies from residents who have participated in an atrial fibrillation pilot. Key points included: • The staff at the stroke service were very approachable and put the residents and their families at ease. • The smartphone application which monitors the heart's rhythm was easy to navigate and allowed for nurses to detect arrythmia via a dashboard. • Strokes were prevented due to atrial fibrillation being detected at an early stage, allowing for medication to be administered within 48 hours. The Chair thanked TD and SK for their feedback on services and members discussed the following points: • Members apologised to TD for the negative experience she detailed and provided assurance that valuable learning will be taken forward. • It was recognised that there is a need for accuracy in diagnosis and for better communication between health and care providers to be strengthened in order to minimise any delays between referrals and treatment. • The Board also recognised the importance of consistent, person-centred support for those who have a long term condition, including the positive value of peer support. • Significant work is happening through the Long-Term Conditions (LTC) workstream to enhance health professionals' knowledge of how to manage LTCs, rescue packs and access points. • It is important that care is integrated around the resident and that they are involved in their treatment plans. There should be a change in narrative between clinicians and their patients from "what is the matter with you?" to "what matters to you?". • There is a need to ensure that feedback is provided to residents that raise concerns and complaints to demonstrate that they are being listened to and to improve as a health and care system. • Best practice should be shared across the system to enable learning and improved outcomes for all residents of north east London. The ICB board thanked TD and SK for sharing their stories and noted the key points arising from the resident story.
3.0	**Chair and chief executive reports**
3.1	Chair's report
	MG presented the report which provided an update on the most significant activities undertaken by the Chair and non-executives since the last ICB board meeting. The following key areas were highlighted: • The Chair reflected on the outcome of the Lucy Letby trial and the anguish experienced with loved ones. She also acknowledged the impact this has had on the health and care workforce, who have been shocked by her actions. It was important to reflect and take action across the NHS, locally as a system and nationally, to improve patient safety and to ensure these crimes do not occur again. • The Fit and Proper Person Test (FPPT) Framework outlines how ICBs must retain certain information assuring that each board member is fit and proper, provides a set of core elements for the FPPT assessment of all board members, and provides a new way of completing references. Its purpose is to strengthen individual accountability and transparency for board members, thereby enhancing the quality of leadership and effectiveness of Boards. It

	is recommended that FPPT oversight is delegated to the Workforce and Remuneration Committee and the Non-Executive Remuneration Committee, with exception reports to the Board. • NHS England (NHSE) has issued updated NHS enforcement guidance that describes the approach NHSE will take to using its enforcement powers. There is to be a new two-tier intervention process for ICBs, as there is with NHS Providers, which involves a first stage of 'undertakings' and a second stage of 'directions'. NHS England will consult with ICBs when considering enforcement action in relation to providers. • The four associate non-executive appointments are due to cease on 31 December 2023, which will result in a lack of non-executive capacity for committees and a lack of independent oversight, in particular for the chairing of the Finance, Performance and Investment Committee (FPIC), and for clinical and care professional independent scrutiny. In addition, feedback has been that, whilst the contribution of associates has been very positive, the lack of a direct connection to the Board has made it more difficult for the post holders to gain an understanding of the wider context. In response, the recommendation of the Non-Executive Remuneration Committee is that we appoint two additional independent non-executive members to the ICB board when the tenure of the current four associate non-executive members comes to an end. If agreed, the current tenure of the associate non-executive members would need to be extended until March 2024 to enable sufficient time for recruitment. • NHSE's annual assessment of our ICB effectiveness resulted in an overall positive report with some areas where we need to provide clarity such as safeguarding arrangements and identifies good work we should build upon, for example with our approach to health inequalities. This annual assessment is in addition to CQC inspection and our own annual self-assessment of the effectiveness of our governance arrangements in helping us move towards our purpose and fulfil our statutory duties. Members discussed the report with key points including: • Members welcomed the introduction of the FPPT and additional non-executive members and highlighted how this will strengthen the system. • Concerns were raised that NHS England's annual assessment did not reference partnership working, which is a key component of the ICB. Members were advised that this has already been fed back to NHSE by the Chair. • Consideration should be given to how we structure Board reports to enhance member's curiosity and enable appropriate challenge. • There are varying approaches across the boroughs to safeguarding and those with special educational needs and disabilities, therefore it could be beneficial to prioritise these areas to have a consistent approach across north east London. The ICB board: • Noted the requirements of the Fit and Proper Person Test (FPPT) and **agreed** that FPPT oversight is delegated to the Workforce and Remuneration Committee for executives and partner members and to the Non-Executive Remuneration Committee for non-executives. • **Approved** the Non-Executive Remuneration Committee's recommendation to appoint two non-executive members, one providing additional financial and performance insight and the other clinical and care professional insight. An application will be submitted to NHSE to make the necessary changes to

	the ICB constitution and an update will be provided to the board on the outcome. • Noted the verbal feedback from the Integrated Care Partnership (ICP) steering group and the NEL non-executive community, the NHS England enforcement guidance and ICB plans for an integrated approach to judging our effectiveness as a Board and as an Integrated Care System.
3.2	Chief executive officer's report
	ZE presented the report and explained the following key points: • There has been continued pressure in urgent and emergency care across the system. We are expecting another challenging winter, with Covid infections currently increasing, concerns about the level of other respiratory diseases and significant pressure on households from the cost of living. We also anticipate sustained periods of industrial action from doctors and consultants. Managing the impact of ongoing industrial action through the winter will add further challenge and create further risk across a system that will already be operating at significant levels of pressure. A system resilience plan is in place which includes a range of schemes, including a significant expansion of virtual wards and the development of a new system co-ordination centre. • The Integrated Care System (ICS) is working in partnership to address violence against women and girls (VAWG) and have met with the Deputy Mayor of London for policing and crime to discuss the system wide approach needed to tackle VAWG. A number of actions were agreed including hosting a system wide workshop and pledges have been agreed across London which the ICB is committed to and which will continue to discuss with partners to ensure these are delivered. • A new research paper on Sexual Misconduct in Surgery contains findings that are deeply concerning and it is important that the ICS does everything it can to ensure this does not happen. The Board is asked to sign up to a new organisational charter on sexual safety in healthcare which has been published by NHSE. This outlines a commitment to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce and includes a number of principles to adhere to. Members discussed the report and points included: • Members were supportive of the pledges, but requested a more condensed version which is easily digestible. It was also highlighted that there is a need for a plan or policy on sexual safety to build on the pledges that we are committing to, which could be included within the women's health and care strategy. A workshop is planned during the 16 days of activism in November to discuss 'what does this mean in your practice' which will enable this work to be woven through and embedded everything we do for our residents. • A previous commission into domestic abuse highlighted that an overarching message from survivors was that they need to be believed. This could be a powerful statement from our ICS and embedded in all areas of work. It is also important that we codesign the strategy with residents that have lived experience, which the voluntary, community and social enterprise (VCSE) sector could assist with. The ICB board noted the report and **agreed** to formally sign the new sexual safety in healthcare organisational charter and commit to the priorities and pledges outlined.

4.0	**Quality**
4.1	Deep dive: Primary Care in north east London
	BM presented the deep dive into primary care in north east London and key points included the following: • Primary care services include general practice, dentistry, ophthalmology and pharmacy and there are over 1000 primary care service providers in north east London, which operate across seven places. • Activity in general practice has increased, primarily due to the Additional Roles Reimbursement Scheme (ARRS) which is a key part of the government's manifesto commitment to improve access to general practice. Through the scheme, primary care networks (PCNs) can claim reimbursement for the salaries of 17 new roles within the multidisciplinary team, selected to meet the needs of the local population. In expanding general practice capacity, the scheme improves access for residents, supports the delivery of new services and widens the range of offers available in primary care. • Primary care is facing significant challenges in different areas which include variation within the provider landscape, an aging workforce, suitability of estates and providers handing back contracts. • To address the challenges being faced and to implement the recommendations of the Fuller Stocktake, a primary care improvement programme has been created with four workstreams focussed on same day access, continuity of care, people, and workforce. Strengthening Primary Care Network (PCN) infrastructure is a key priority within the improvement plan, identifying opportunities to employ a workforce that has the right skill mix to meet the need of local communities within a neighbourhood. • The digital first programme will support innovation and transformation across a number of workstreams including social prescribing, virtual consultations and an improved digital pharmacy offer. • Training hubs have developed a comprehensive healthcare assistant training programme for new and experienced NEL staff joining primary care. To date 299 of the 350 available places on the programme have been filled, and 11 have enrolled on a programme for staff with a minimum of 18 months experience to develop advanced skills. • There is a need to safeguard and support colleagues who are struggling so they can continue to provide the care residents deserve, whilst enabling those who are ready for excellence need to be able to innovate and improve. Both need to be done simultaneously to enable effective transformation. Members welcomed the deep dive report and key points that were discussed include: • The importance of the Primary Care Colloborative and also of primary care borough leadership. • It is important to support our residents by enhancing the interface between provider collaboratives, as approximately 90% of mental health care is provided by friends and family rather than healthcare services. • The health and social care workforce are under pressure to not only deliver quality care to residents today, but to also consider how they can improve tomorrow. It is important not to lose the essence of primary care offer, which deals with complexity daily. The GPs in north east London are ambitious for our populations, therefore support is required from social care and NHS Trusts to drive improvement.

	• Fragmentation is an issue; however, the east London patient record is an improvement which will help in this area. • Some equalisation can be conducted locally, such as the local enhanced service equalisation agenda which will ensure boroughs receive the correct level of funding over time. • There may be a need for new dentistry and GP contracts, however this would need to be considered nationally. • There is variation in regards to PCN effectiveness, and not all are geographically based, however they are instrumental in how integrated neighbourhoods will be built. Once dentistry, ophthalmology and pharmacy are integrated into PCNs, this will enable a more holistic offer and improve effectiveness. • The community pharmacy consultation scheme is a similar offer to the minor ailments scheme with appointments available in pharmacies for minor ailments. There is also a plan this winter, pending national legislation, for pharmacists to prescribe for up to seven new conditions which would reduce the burden on general practice. The ICB board noted the deep dive report.
4.2	System Quality Dashboard Prototype
	DJ presented the report and explained the following points: • This report presents a prototype System Quality Dashboard based on three of our ten quality pillars. The purpose of the System Quality Dashboard is to provide a system-focused data-driven perspective on quality in north east London; issues and responses to them are identified from, and should be responded to strategically, through a range of processes including commissioning, service development and system-wide programmatic work. • The data is health driven as it is validated and taken from the National Quality Board and Care Quality Commission (CQC). There is not currently a source for validated local authority data, however business intelligent teams are working on this to ensure we have a full system oversight. • Cancer screening is low in particular communities, which was discussed at the Quality, Safety and Improvement Committee (QSIC), so the dashboard will enable a narrative to be developed which will include points such as the actions being taken to address this. The actions will be system-wide and primary driven by the provider collaboratives, as well as residents. Members discussed the report and key points included: • The Board welcomed the report and noted that it was prepared in response to their request to understand quality across the system. • It could be beneficial to have metrics that are specific to north east London rather than solely national metrics. • It would be helpful if the data could be broken down by borough, in addition to north east London-wide, as this could assist the borough partnerships with their delivery of services. • The statistical progress charts are extremely helpful; however, these could be strengthened by the inclusion of targets. • It is important to maintain a focus on quality; if there are too many metrics this could lead to a focus on other areas. • The Mental Health, Learning Disability and Autism Collaborative has service user derived outcomes which are an articulation of what our residents are looking for in terms of outcomes and quality. It could be beneficial to link this in with the dashboard as this could shape health and social outcomes. It

	could then also be linked to the strategic outcomes framework for the ICP strategy. • Consideration should be given as to how we draw on success measures identified in the Big Conversation and from the VCSE sector. • It is beneficial for the board to see this work at an early stage for assurance and would like to receive an updated version once it had been discussed in other fora. The ICB board noted the report.
4.3	Freedom to Speak Up services across NEL Integrated Care System
	DJ presented the report and highlighted the following points: • Following the recent trial of Lucy Letby, NHS England wrote to ICBs requesting that NHS leaders and boards ensure proper oversight and implementation of their freedom to speak up service; in particular, that all staff have easy access and information on how to speak up, that guardians are aware of the nations speaking up support scheme, that staff who have cultural barriers or in lower paid roles are supported to speak up, and that boards are assured staff are confident in reporting issues and are regularly reviewing available data. Whilst this was an organisational request, the ICB has decided to review this system-wide as an ICS. • North East London ICB has a smaller workforce in comparison with its partner NHS Trusts and has had 16 concerns raised over the last calendar year. • Where patient safety concerns are raised and there are impacts on our residents, these are tracked through by guardians and reported through patient safety incident reporting and performance indicators. Members welcomed the report and discussed the following points: • ICBs nationally have a duty to encourage speaking up in healthcare as well understanding arising themes from concerns being raised, however in north east London we are looking to extend this by including all system partners, not just healthcare organisations. • It is important to recognise that the Letby case did not just involve clinical concerns, but also organisational. Therefore, it is important that when concerns are raised by staff, they are also reviewed in an organisational context. • It would be useful to add where concerns had been resolved for the ICB data. • There are staff working in joint roles across the partnership, so it is important that these staff know where they should report concerns to. It would be beneficial if this was reported on, in additional to local authority data. • Due to anonymised reporting, it is difficult to analyse the concerns that are raised to identify any system-wide concerns. • There have been some modelling suggestions for freedom to speak up in primary care which the primary care collaborative could consider. **ACTION:** Proposal for an appropriate freedom to speak up service for the primary care workforce to be brought to a future Board meeting. The ICB board: • Noted the need for an appropriate freedom to speak up service to be developed with primary care colleagues recognising the makeup of the

	primary care workforce across north east London. It was suggested this is developed collaboratively and a proposal brought to a future Board as part of the system approach. • Considered the exploration of the benefits of a system view of speaking up across health care organisations, with collaborative and system oversight led by the ICB non-executive and executive leads.
5.0	**Finance and performance**
5.1	Finance overview
	HB presented the finance overview report and explained the following points: • The month 5 year-to-date position across the NEL system is a overspend variance to plan of £74m. This is made up of a provider overspend variance of £58m with an ICB overspend variance of £16m. The growing industrial action costs are currently included in this figure and are in excess of £17m. • The ICS as a whole is still forecasting to deliver a breakeven plan in line with the operating plan and national reporting protocol. However, as reported previously the year-to-date position indicates a substantial risk to delivery. This has resulted in a formal financial recovery plan (FRP). The FRP has been signed off by ICB executives, Trust Chief Executive Officers and Chief Finance Officers, and shared with regulators. The FRP assessed the impact of cost improvement schemes (CIPs) and other corrective actions, still leaving a potential system year-end gap of £55m. Regulators have requested that further work is undertaken to bring the position back in line with the plan. • Several measures are being put in place as part of the FRP which include the appointment of a financial recovery director and introducing a double lock sign off process for expenditure over £50,000 between the ICB and NHS Trusts. The recovery director will bring additional capacity to a system with existing expertise. • They key pressures at a system level include: o Additional costs in relation to inflation being higher than planned levels. o Agency usage is above the cap set by NHS England and there are reported pressures in relation to the agenda for change pay award. o The impact of industrial action has impacted Trusts in terms of the cost to backfill staff and also on the ability to deliver elective activity. o There is a year-to-date under delivery of efficiency and cost improvement plans of £33.1m. • A separate issue is that we have overcommitted on our capital and have the lowest capital allocation in London. A detailed report on this will be presented to the Finance, Performance and Investment Committee. • It is recommended that the Scheme of Reservation and Delegation (SORD) is amended so that the level of approval for business cases at the Finance, Performance and Investment Committee (FPIC) is raised from £20m to £60m in order to allow time for expert scrutiny at the committee. Business cases over £60m will be reviewed by FPIC with a recommendation being made to the Board on whether approval should be given. Members discussed the report and key points included: • There is a need to review how continuing healthcare is purchased, opposed to the levels of purchasing, as beds within the same care home can have varying costs. The system is trying to get improved adherence to the any qualified provider (AQP) regime which will enable a fixed price for activity.

	We are also looking to increase the price which will enable better compliance with the lower rates and avoid spot purchasing at a higher cost. • The role of the system recovery director is to bring additional capacity to existing expertise which will enable the ICB to seek assurance on the current CIPs and identify additional improvement plans. The role will also enable the ICB to work through scrutiny received from regulators which requires additional capacity, away from business as usual, and a specific focus. • A system recovery board is being developed which will include non-executive representation and will also review the impact on quality and safety. • The costs of the industrial action are being collated and NHS England is working to identify an appropriate metric, so there is a possibility that additional support will become available. The ICB board: • Noted the contents of the report and the risks to the financial position. • **Approved** the recommended changes to the scheme of reservation and delegation which include: o The level of approval for business cases is increased for Finance, Performance and Investment Committee (FPIC) to £60m. A report showing the approvals made by FPIC will be included in the Board report for purposes of assurance. o FPIC reserves the right to send business cases to the Board for approval regardless of limit, if the committee thinks it is in the best interests of the ICB to do so. o Over £60m business cases will still be reviewed by FPIC with a recommendation being made to Board on whether approval should be given.
5.2	Performance overview
	HB presented the performance report and highlighted the following points: • The total waiting list in planned care has risen again in June 2023, rising in five of the last six months, while the numbers of very long waiting patients continues to fall. The total waiting list and number of patients waiting greater than 65 weeks are above trajectory. • There is an improved performance in cancer as the number of patients waiting more than 62 days for cancer treatment has now fallen. Following a national consultation, NHSE has described changes to the reported cancer standards. These will be implemented from October 2023, with the first data reported in December. North east London will monitor these standards in shadow form from July 2023 data. The changes announced include the removal of the two-week wait standard in favour of a focus on the Faster Diagnosis Standard, and the rationalisation of the ten standards into three core measures for the NHS. • Urgent and emergency care (UEC) performance has shown an improvement against the 4-hour Emergency Department (ED) standard with the overall trajectory being met. The system will be supported in Tier 1 (highest risk) for UEC services for 2023/24. The national UEC team will agree a concordat with NEL ICB and NHSE London. Members discussed the report and key points included: • There is a need for the system to communicate that some services that are outside of the industrial action are still operational, such as blood testing.

	• It was beneficial to see babies, children and young people included within the report as they are one of the flagship priorities. A deep dive into this area is on the Board forward plan and scheduled for March 2024. • There has been a focus on working with London Ambulance Service to reduce the 45-minute handover times and also to improve category 2 response times. A pilot scheme was introduced on 26 July 2023 and performance has improved considerably since. Due to the response, we are continuing with the implemented process even though the pilot has officially ended and an evaluation will take place in due course. • The increase in elective care waiting times is in direct correlation to the industrial action. More complex patients are having procedures cancelled earlier and there is a real need for recovery. • It could be beneficial to demonstrate the comparisons in data between providers in order to highlight best practice and identify learning opportunities in deep dive reports. • It would be helpful to include more information regarding how we are addressing diagnostic performance in the next report and the work around physical health checks could be included in the system quality dashboard. The ICB board noted the report.
6.0	**Governance**
6.1	Annual report and accounts
	CP presented the report and outlined the following points: • NHS North East London ICB submitted an annual report and signed final audited year end accounts for the period 1 July 2022 to 31 March 2023 to NHS England by 30 June 2023 and published this on its website by the required deadline of 28 July 2023. • A summarised, more user-friendly version of the annual report has been produced which will be shared more widely with local people and stakeholders and an easy-read version will be available. The ICB board noted the report.
6.2	Governance update
	CP presented the report and explained the following points: • At the last meeting, the Board approved the revised Barking and Dagenham ICB sub-committee terms of reference to reflect the committees in common approach. Given the Chief Participation and Place Officer is the ICB Senior Responsible Officer (SRO) for place, the Board is asked to approve her membership on this committee. • Work is continuing to review the arrangements to provide assurance and oversight of the delegation agreement with NHS England for dentistry, optometry and pharmacy services. This review is ongoing and an update will be presented at the next meeting. In the interim, any decision required can be taken in accordance with existing governance by officers in accordance with financial scheme of reservation and delegation. • Further time is being taken with NHS Foundation Trusts to allow the functions section of the Mental Health, Learning Disability and Autism (MHLDA) Collaborative Joint Committee terms of reference to be developed in workshops with NHS England (who are working with the MHLDA collaborative colleagues as part of the Provider Collaborative Innovators Scheme) and lawyers Browne Jacobson.

	• A governance improvement plan has been developed with engagement from board and committee members to address the issues outlined in responses to discussions around board and committee effectiveness. The plan also includes details of the implementation timeline of the new system procured by the ICB, Modern.Gov, which will manage and deliver an efficient board/committee paper system for ICB board and committee members. The ICB board: • **Approved** that the Chief Participation and Place Officer will be added to the membership of the Barking and Dagenham ICB Sub-Committee • **Approved** the updated Governance Handbook. • Noted the provider collaborative update and the proposed governance improvement plan.
6.3	Board Assurance Framework
	CP presented the report and explained that the board assurance framework has been amended to strengthen the approach to risks to finance and highlights the financial fragility across the system. Members discussed the board assurance framework and points included: • It would be helpful to have local authorities referenced more within the mitigations to the risks we have as a system. • In relation to the risk regarding wider determinants of health, it would be helpful if we could have assurances and mitigations in place that ensure all parts of the system take the same approach if needed to respond to an environmental event. It is also important to identify good practice, such as Liveable Neighbourhoods. The ICB board noted the board assurance framework.
6.4	Committee exception reports for information
	The chairs/ vice-chairs of the committees of the Board each presented an exception report which highlighted the work undertaken by its members since the last meeting. The reports included updates from: • Executive Committee • Audit and risk committee • Workforce and remuneration committee • Quality, safety and improvement committee • Finance, performance and investment committee • Population health and integration committee. The ICB Board noted the exception reports.
7.0	**Board forward plan**
	The Chair recommended the following items be added to the Board forward plan: • Long term conditions and prevention deep dive. • A report that is a roadmap on integration which explains how we are integrating services, our approach and our priorities. **ACTION:** Long term conditions and prevention deep dive and roadmap on integration to be added to the Board forward plan. The ICB board noted the forward plan.

8.0	**Questions from the public**
	There were no questions received from members of the public.
9.0	**Any other business and close**
	There were no further items for discussion.
	Date of next meeting – 29 November 2023

NHS
North East London
Integrated Care Board

ICB board – action log

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
4.2 Financial strategy	29.03.23	Henry Black to arrange a system workshop to develop shared financial understanding of each sector.	HB	Jan 24	The session is being scheduled in January 2024.
1.4 Actions log	27.09.23	Francesca Okosi to present an update on the Integrated Care System (ICS) after action review of the industrial action at a future meeting.	FO	Mar 24	Forward planning meeting scheduled with FO and governance team on 30.11.23 to discuss and confirm date.
4.3 Freedom to speak up services	27.09.23	Proposal for an appropriate freedom to speak up service (FTSU) for the primary care workforce to be brought to a future Board meeting.	DJ/ FO	Mar 24	FTSU services for the primary care workforce is the responsibility of primary care providers. The ICB will seek assurance from all system partners that they have an effective FTSU process in place.
7.0 Board forward plan	27.09.23	Long term conditions and prevention deep dive and roadmap on integration to be added to the Board forward plan.	Chair	Nov 23	Complete. Items added to Board forward plan which is included in the Board paper pack.

CLOSED ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
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	Proposed amendments to the Scheme of Reservation and Delegation (SORD) are included in the finance report.

CLOSED ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
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	Complete. The external auditor annual report can be found here.
4.1 NEL system people and workforce strategy	26 July 2023	Chair and Diane Herbert to take forward the feedback and consider how the framework can be structured.	MG/ DH	Sep 23	Complete. A meeting regarding the recommended priorities has taken place and the final version of the amended strategy will be presented to the Board in November.
5.1 Deep dive: health inequalities	26 July 2023	Johanna Moss to provide a list of the health inequalities architecture in north east London to members.	JM	Sep 23	Complete.
5.2 Quality oversight and support report	26 July 2023	Diane Jones to share the paper on the pillars of quality with the provider collaboratives	DJ	Nov 23	Complete
6.1 Month 3 2023/24 financial overview	26 July 2023	Detail regarding the financial recovery plan to be presented at the next meeting.	HB	Sep 23	Complete.
6.2 Performance report	26 July 2023	Henry Black to discuss with provider colleagues how learning from after action reviews of industrial action events is being shared.	HB	Sep 23	Complete. Learning from after action reviews is discussed at the UEC Acute Provider Collaborative Programme Board.
7.1 Governance handbook amendments	26 July 2023	Acute Provider Collaborative Joint Committee quorum to be amended. A committee improvement plan to be presented at the next meeting.	CP	Sep 23	Complete. Complete.
7.2 Board Assurance Framework	26 July 2023	Henry Black to review the likelihood score and quality impacts for risk CFPO14/15.	HB	Sep 23	Complete. All risks have been reviewed and updates

CLOSED ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
					are included within the Board Assurance Framework.

NHS North East London ICB board

29 November 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 the outcomes of the October meeting of the North East London Integrated Care Partnership and the North East London Chairs and Non-Executive Members which should inform our Board discussions. It also provides an update on the Chair's activities. Recommendations: • That the Board receive and note the report
Action required	For Noting
Previous reporting	North East London Integrated Care Partnership meeting 4 October 2023 North East London Chair and Non-Executive Member Meeting 19 October 2023
Next steps/ onward reporting	None
Conflicts of interest	None
Strategic fit	The ICS aims this report aligns with are: • 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 report emphasises the importance of the Big Conversation in determining success measures that are defined by local people and the work with partners to address health inequalities.
Impact on finance, performance and quality	The effective and proactive addressing of inequalities and working with others across London to build expertise and joint action will ensure we are improving quality, performance and value for money.
Risks	Understanding the national context and the views of our system partners, residents and communities will assist identifying and mitigating risks.

1.0 Introduction

1.1 There have been three recent national announcements that I would like to bring to the Board's attention. Subject to parliamentary scrutiny and agreement, the Department of Health and Social Care intends for a new Provider Selection Regime (PSR) to come into force on 1 January 2024.The PSR will be a set of new rules for procuring health care

services in England by organisations termed relevant authorities, which includes Integrated Care Boards. The PSR has been designed to introduce a flexible and proportionate process for deciding who should provide health care services, that allows for collaboration to flourish across systems and importantly ensures that all decisions are made in the best interest of patient and service users. The PSR will be introduced by regulations made under the Health and Care Act 2022 and NHS England has published draft statutory guidance to support implementation of the PSR regulations, along with a draft toolkit. A future meeting of the Board will provide an opportunity for the Board to understand their new responsibility in more detail.

1.2 Significantly, we have been formally notified that the Thirlwall Inquiry has started its work and will soon be requesting evidence from all trusts with neonatal units so that it can better understand their work and North East London will, of course, fully engage. The Thirlwall Inquiry was established following the conviction of Lucy Letby and will investigate three broad areas, which are:

- The experiences of the Countess of Chester Hospital and other relevant NHS services, and of all the parents of the babies named in the indictment.
- The conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives including whether suspicions should have been raised earlier, the response to concerns and whether the trust's culture, management and governance contributed to the failure to protect the babies.
- The effectiveness of NHS management, governance and culture in keeping babies in hospital safe and well looked after.

1.3 NHS England has launched its first ever anti-racism framework, the 'Patient and Carer Race Equality framework' (PCREF), for all of England's NHS mental health trusts and mental health service providers. This mandatory framework will support trusts and providers on their journeys to becoming actively anti-racist organisations by ensuring that they are responsible for co-producing and implementing concrete actions to reduce racial inequalities within their services. It will become part of Care Quality Commission (CQC) inspections. The PCREF will support improvement in three main domains: leadership and governance, data, and feedback mechanisms. The anti-racism framework brings ground-breaking change to the sector, building on progress achieved locally, and promoting a whole new dimension of coproduction, where individuals and communities are at the heart of the design and implementation of the services they need

1.4 The remainder of this report provides feedback from the Integrated Care Partnership, which met on 4 October and considered workforce strategy and emerging themes arising from our Big Conversation. It is also sharing key points from the regular meeting held between Trust Chairs and the ICB Non-Executive Members and Associate Members, which considered workforce productivity and received an update on the System's work in relation to migrant health. The outcomes of their discussions are reported here to inform our own discussions.

2.0 Integrated Care Partnership

2.1 The North East London Integrated Care Partnership (ICP) met on 4 October 2023 and discussed our workforce strategy and emerging themes from the Big Conversation, with the key conclusions summarised below.

2.2 Workforce Strategy**:** The ICP was appreciative of the direction of the strategy and asked that it:

- Is explicit throughout that this is a strategy for the whole of the NEL partnership and not just the NHS.
- Highlights the positives of health and care career paths.
- Ensures a joint induction across care and health.
- Recognises that the voluntary care sector (VCS) has similar issues such as staff retention, and an aging workforce and therefore should be included in identifying career opportunities, in career transition opportunities and in discussion with younger people about roles.
- Addresses the need to support the London Living Wage and the challenge that the pay differences for outer London boroughs vs inner London create.
- Considers how to help service users into our workforce.
- Supports the recruitment of volunteers, so for example, if there is a recruitment hub could we also consider using this to attract people that wish to volunteer in health and social care.

2.3 The Board is asked to keep the ICP insights in mind when considering the People and Culture Strategy which will be presented at our January Board meeting.

2.4 Big Conversation: The meeting received a report on the five themes emerging from the Big Conversation and were asked to consider what would be important when considering success measures under each.

2.5 The ICP's conclusion illustrates how complex establishing a shortlist of key success measures will be but also identified some cross-cutting areas, such as data and communication. This is why our follow up ICB event to test the outcomes of this phase of our Conversation with our people and communities is so important:

2.5.1 *Compassionate care and support which feels human, culturally competent and personalised*: The ICP discussion highlighted the importance of qualitative feedback that covers a whole pathway of care, where local people define what is great care and where people feedback on a whole range of professions, from front line worker to specialist consultant and social worker to voluntary sector support.

2.5.2 *Organisations working closely together to provide joined up care and support*: The Partnership meeting emphasised the need to measure the number of re-referrals, with local people identifying whether they have felt like they have dealt with one system that has a shared voice and shared language. Information, communication and data sharing were key to this area and were also a common theme throughout.

2.5.3 *Improved access to primary care as for the majority of local people, it is their key connection with health services*: The Partnership emphasised the need to recognise that improved access to primary care is not just about the number of appointments but the continuity of care and ease of access to a range of professionals as part of the wider primary care team, so that a range of services can be accessed locally. The meeting also suggested that there should be a particular focus on those with long term conditions.

2.5.4 Clearer ways to support everyone to be physically and mentally well in their local communities by incorporating the wider determinants of health (employment, housing, environment, poverty): The type of success measures that would be useful for this theme were identified and were those that could evidence how residents are being supported to be well, confident, resilient and

in control. The importance of access to information about support including access to social prescribing and care navigators were also highlighted, along with the need to measure our success as anchor institutions.

2.5.5 *Greater opportunities to work in health and care with flexible and accessible routes to apprenticeships, work experience and employment*: The importance of success being defined by non-traditional routes and ease of access through a joint health and care system portal, that included voluntary sector roles, were emphasised. Success would also need to be defined by how people were treated and aided to find the right role and how we had been successful in targeting under-represented groups.

2.6 In addition to the above, the ICP received reports on the System Planning Cycle, where it raised the need to discuss this approach with Health and Wellbeing Boards, the need to align financial and workforce planning and to consider the capacity of partners to engage. It also approved a recommendation to include a care provider member on the partnership and to undertake a deep dive into housing and the environment at a future meeting.

3.0 Chair and Non-Executive activities

3.1 Chairs and Non-Executive Member meeting: The Chairs discussed the system approach to supporting migrant health, including considerations of north east London becoming a place of sanctuary. It was recognised that migrants experienced specific health challenges and are a group that we are working with as part of our responsibility to reduce health inequalities and improve population health. We also discussed the importance of the system's work on workforce productivity, noting the specific challenges in north east London and highlighted the need to develop a joint and evidenced understanding of our productivity that we can share with NHS England. Finally, the meeting was updated on the system's financial recovery and particularly considered the financial impact of industrial action, asking that this be evidenced so that we can understand where we would be without it.

3.2 National and London Meetings: I was privileged to be part of a Department of Health and Social Care (DHSC) Ministerial Panel sharing lessons about integrated care systems, with other ICS colleagues as part of the Department's ICS week. The panel was chaired by Lord Markham, Parliamentary Under Secretary of State and, Matthew Style, Director General, NHS Performance and Policy at the DHSC was also a panel member. It was pleasing to see the interest of over 100 DHSC attendees and the active engagement of the Minister and senior officials. The panel was a success and will be followed up by a visit to north east London by Deputy Director Jennifer Benjamin, who will also spend some time shadowing me.

3.3 We were pleased to host the meeting of the London People Board at the ICB's Stratford office this month and I was personally pleased to work with our Hackney Director of Public Health, Sandra Husbands, to facilitate a London Health Equity Group meeting on the London anti-racist approach when tackling health inequalities; a meeting chaired by Andrew Blake-Herbert. The London People Board featured a presentation on the NHS Equality, Diversity Inclusion (EDI) Plan, published in June this year, and which focused on London's progress against the six high impact actions. (These actions are: 1. for each Board member to have an EDI objective; 2. to embed inclusive recruitment and talent management; 3. to develop an improvement plan to address pay gaps; 4. to develop a plan to address health inequalities within our workforce; 5. to implement comprehensive induction and support for international recruits; and 6. to create an environment that

eliminates bullying and harassment and physical violence. As an ICB we need to have oversight of how we are progressing against the six impacts and this will be included within our own EDI action plan that is under development. The London People's Board's conversation focused on how we could best support the NHS in London to move forward on their commitments, with a focus on Once for London training and development so that we can ensure our public commitments more rapidly move to action and enabled a sustained change in culture. This focus on culture change was also seen through our discussion on the London approach to the Thirwell Inquiry and the Breaking the Silence – Sexual Misconduct in Surgery report, with a clear intent from all London partners in the room focus on prevention as well as support. We also received a presentation on the social care workforce in London, which is more challenged than the NHS in terms of vacancies and turnover. We committed to ensuring that we collaborate, particularly on recruitment and development of staff. The London Health Equity Group conversation has a similar focus on action, with a renewed commitment to our anti-racist approach to tackling health inequalities and a new commitment to quickening our pace to support change.

3.4 NEL ICS: National themes have been reflected in our local workshops. I was pleased to Chair our 31 October workshop on how to be an anti-racism system, which focused on the action that we need to take so that we proactively address the inequalities experienced by our global majority population and staff. The meeting highlighted the need, rather like our ICP, to work across pathways; the need to identify how we were making a difference as a system to add value to our individual actions; the importance of data and the essential importance of working with our people and communities. Embedding knowledge, understanding and action, by going beyond training to embed anti-racism in all that we do was highlighted as critical. Also, amongst the insights shared was the importance of celebrating success and the importance of developing a charter with a supporting framework of measures, and action plan. The meeting was concerned that we also focus to ensure people are supported to speak up when they believe that we are not being proactively anti-racist, particularly ensuring a safe space and support for those directly impacted.

3.6 Place-based Partnerships: You will recall that each Non-Executive Member has been aligned to a place within our system and as a consequence I have been getting to know the work of our Havering partnership more closely. Meeting with key stakeholders and attending a partnership meeting. It is clear that there is a joint ambition, an understanding of their communities along with an understanding of joint challenges. I know this is true of all the local partnerships, as is their interest in more delegated decision making. What I found particularly interesting was their commitment to work together to assist the financial viability of all partners, with a real focus on these being system challenges rather than individual organisational challenges. I also enjoyed meeting Healthwatch volunteers, who generously give their time and energy to help us improve. The part of the meeting I attended focused on primary care and accessible services for deaf residents and those with learning disabilities, where it became clear that volunteering went beyond enter and view visits and ensuring voices are heard, with volunteers assisting to develop community responses and networks. I thank all our volunteers for all that they do.

4.0 Recommendation:

4.1 To receive and note the report.

Marie Gabriel – Chair: 30/11/23

North East London
Integrated Care Board

NHS North East London ICB board

29 November 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	The board is asked to note the report.
Previous reporting	N/A
Next steps/ onward reporting	N/A
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
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 Since the last meeting of the board, the system has continued to be under significant operational pressure from industrial action, ongoing high levels of demand and financial pressures. Although industrial action is largely confined to NHS providers, local authorities are equally facing demand and financial pressure. The later part of the agenda includes an item on the financial position of the NHS part of our system but I would ask the Board to note that local authorities are currently consulting on their budgets for the next financial year which are requiring substantial levels of savings to be found. London Councils, the representative body for all London local authorities, noted in their briefing document ahead of the autumn statement that 9 in 10 Boroughs are overspending in the current financial year, and that outer London boroughs with the lowest per capita funding in the country are under particular pressure. The main drivers of these pressures are adults and children's social care,

and homelessness, with the level of rough sleepers in London having risen to the highest level since the rough sleeper count began (up 22% on the same period last year) and levels of other forms of homelessness also being extremely high.

These levels of financial challenge across our system are placing all organisations under significant pressure and it is vital that we continue to deepen our partnership working to understand how best to use our scarce resources in the most effective ways to support local people.

The ICB was required to submit on 22 November a revised operating plan for H2, setting out our plans to deliver on the system financial targets for the year and to maintain trajectories for specified operational plans including urgent and emergency care, cancer and people waiting a long time for treatment. We are in the process of discussing the submission with NHS England and will update the Board and our reporting in due course with any resulting change. The Board will be updated verbally with any updates available by the time of its meeting.

Despite these operational challenges, we have continued to work on our core long term objectives. We held a system wide event in November to launch our new health equity academy bringing together a huge amount of great practice across north east London. We also held a system wide workshop to refresh our approach to becoming an anti-racist system and in particular to develop a clear strategy and workplan, as detailed in the Chair's report. We also held ICB staff events across two days to develop our organisation to more effectively deliver our core aims.

2.0 Winter

Further to my last report we are now embedding much of our winter planning as we head in to winter properly. We are currently in the process of developing our strategic coordination centre (SCC) for North East London which is due to launch on 6 December. This is a central co-ordination service to providers of care across the Integrated Care System (ICS) footprint, with the aim to support patient access to the safest and best quality of care possible.

The SCC is responsible for supporting interventions across the ICS on key systematic issues that influence patient flow. This would include a concurrent focus on Urgent and Emergency Care (UEC) and the system's wider capacity including but not limited to NHS 111, primary care, intermediate care, social care, urgent community response and mental health services.

The SCC will support proactive coordination of system responses to operational pressures and risks as well as utilising available information and intelligence. The SCC will be physically located in the ICB offices and will operate seven days a week (8am-6pm physically and outside of these hours via the on-call director rota).

3.0 Humanitarian crisis and impact on the local population

Many in our communities and workforce have been impacted by the awful events in the Middle East. Our Jewish and Muslim communities are facing an increase in hate crimes and discrimination and I know that many in our workforce are deeply anxious. As well as ensuring that our staff are supported, this highlights how important it is that we continue to champion our mission and values around promoting equity and tackling inequality and discrimination.

4.0 Embedding equity, equality, diversity and inclusion across the ICB and ICS

4.1 North East London is a vibrant, diverse and fast-growing part of London with a population of over 2 million, rich diversity and huge inequalities. Our health and care landscape across north east London is complex and constantly evolving to meet emerging need and demand – and we understand that local wellbeing is affected not only by the services we commission and deliver but also by our community infrastructure, by poverty and by wider determinants of health such as employment, housing and education.

That is why we are firmly committed to ensuring equity, equality, diversity and inclusion are firmly embedded in everything we do, knowing the difference this makes to our staff and patients. One area of focus is how we ensure equality is underpinned by an anti-racist approach. Across our partners lots of work is underway on this and we heard about some of this good practice as part of our system wide workshop in October. In addition to comments from the Chair in her report I would also add that it was fantastic to be joined by many partners and to hear some rich discussion about what an anti-racist ICS for north east London looks and feels like and the key actions we need to take.

We also launched our health equity academy at the start of November, bringing together system partners to further our ambition of creating meaningful improvements in health equity. The event was really positive, and participants were enthusiastic and engaged, and provided us with many insights that we want to share and take forwards. There was a lot of focus on the crucial role of the voluntary and community sector, the importance of building trust with our communities, and the value of building relationships across sectors. We discussed how we find what is in our control and push further against the powerful forces and wider context including cost of living pressures, eroding of the social safety net and the disproportionate impacts of Covid-19. The Health Equity Academy, which is dedicated to providing the tools, resources, training, learnings and collaboration opportunities that is being developed in north east London.

5.0 Staff away days

We recently held a series of staff sessions to bring ICB staff together to hear from system partners about what working in a system means for them and the role of the ICB in this, and to discuss and agree a set of values for the organisation. At these sessions we also held a number of market place stalls to gather contributions from staff on a number of topics including our ICB operating model, what being an anti-racist system means for the ICB, health inequalities, working practices and staff engagement. It was great to hear from staff about how they would like the organisation to be different going forward and I really appreciated people's honesty in sharing feedback with me, and the senior team. It was also great hearing so many ideas about what has supported great social connection at work for staff in the past, and what they think about how we can do this going forward. Ahead of the staff away days I also brought our wider senior leaders' group together to look at how we continue to refine our operating model, outputs of which fed in to the staff sessions.

6.0 Working with system partners

I have continued to bring together our police borough commanders, Trust and ICB colleagues on a monthly basis to discuss key issues affecting policing and health across our places. The key focus has been on the rollout of Right Care, Right Person which took effect from 31 October. This is an operating model that provides guidance on the way the Metropolitan Police responds to mental health related calls. It is designed to ensure that when there are concerns for a person's welfare linked to mental health, medical or social care issues, the right person with the right skills, training and experience will respond to provide the best possible service. During these really productive conversations we have discussed topics such as training, use of data and key risks and mitigations. Our next meeting will focus on the impact of the changes so far and we will continue to work closely together to manage these.

In October colleagues from north east London and I presented some of the great work going on in north east London to Chief Executives of ICBs and Trusts from across London. Rima Vaid, our clinical director for Newham described how they have achieved high levels of coverage of the population eligible for health checks and the impact of this on prevention, Louise Ashley described the factors behind the success of the partnership in City and Hackney, Amanjit Jund set out how the integrated delivery framework is helping strengthen community-based working, and Charlotte Pomery talked about work at place in Barking and Dagenham as well as the Big Conversation. The presentation was very well received.

7.0 System visits and events

7.1 **Homerton Hospital** – I visited the first half of the new intensive care unit at the Homerton and saw the operational ingenuity and creativity that people bring to work every day so that patients get the best possible care. It is ever more in need at the moment given how full all parts of our system are from primary care through hospitals to social care. I also spent time in the neo-natal intensive care unit (NICU) and saw first-hand the passion and drive of the staff in providing a family centred environment focussed rightly on giving babies the care they need now, but also providing the support that families need to give them the best start in life through breastfeeding support, therapeutic interventions and increasingly focussing on fathers as well as mothers.

7.2 **Women's health hubs** – I met with the teams behind the three north east London women's health hub projects to understand their work and how we can ensure it reaches as many women as possible in north east London. I heard about the development over a number of years of the model in City and Hackney, which has now reached and supported thousands of women to access advice and care, and the developing hubs in Tower Hamlets and Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT). There is a huge amount of learning being shared and lots of examples of how community-based care can prevent the need for women to receive treatment in hospitals, as well as innovative new models of care. However, there are also some areas of acute workforce challenge (such as physiotherapists focussed on women's health) that is hindering our ability to do preventative work.

Zina Etheridge
November 2023

North East London
Integrated Care Board

NHS North East London ICB board

29 November 2023

Title of report	Our approach to system recovery
Author	Sarah See, Managing Director of Primary Care Fiona Ashworth, System Programme Director for UEC Claire Hogg, Director of Planned Care
Presented by	Johanna Moss, Chief Strategy and Transformation Officer
Contact for further information	sarahsee@nhs.net fiona.ashworth5@nhs.net claire.hogg4@nhs.net
Executive summary	Ambitious national programmes have been established to support systems in recovering performance across primary care; urgent and emergency care; and planned care. North East London has established clinically led programmes, informed by resident and stakeholder engagement, to oversee delivery of these plans for our system. These programmes are aligned to our NEL Integrated Care Partnership (ICP) strategy and form the basis of core work set out in our Joint Forward Plan. Our Place Based Partnerships and Provider Collaboratives have a key role in shaping, agreeing and assuring delivery against these recovery plans. This paper provides an overview of the plans and progress underway in primary care; urgent and emergency care; and planned care. For primary care, a summary of progress against the Delivery Checklist for ICBs is included along with risks and mitigations.
Action / recommendation	The Board is asked to note progress against the three recovery programmes. The Board is asked to assure the plan to deliver the Primary Care Access Recovery Plan (PCARP) is sufficiently comprehensive and robust.
Previous reporting	Executive Committee on 9 November 2023.
Next steps/ onward reporting	As part of our integrated system planning process for 2024/25, Place Based Partnerships and Provider Collaboratives will be closely involved in shaping and agreeing specific deliverables for the next financial year.
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 recovery programmes across primary care; urgent and emergency care; and planned care will all result in improved access, experience and outcomes for local residents. Each of the programmes has been designed to enable improvement in key performance indicators through clinically led and resident informed innovation which reduces inequities in both the provision and outcomes of care across north east London. For the PCARP an Equalities and Health Impact Assessment has been completed.
Impact on finance, performance and quality	National funding sources have been made available to the ICB to support general practices and Primary Care Networks (PCNs) to commence the early changes required to move towards modern general practice.
Risks	• Insufficient clinical leadership and project resource to support delivery of the programmes. • Misalignment of national recovery focus and local Place or Provider Collaborative priorities for use of limited resource. • Workforce pressures including availability and morale limit capacity. • For PCARP variation in funding, recruitment & retention of staff, poor quality estate, and increasing rent & service charges affecting the sustainability of primary care services limit delivery at individual practice level.

NHS
North East London

Delivery Plan for Recovering Access To Primary Care

Executive summary

North East London Health & Care Partnership

- The Fuller Stocktake built a broad consensus on the vision for integrated primary care services, and in order to realise this, action is required to take the pressure off general practice.

- The Delivery Plan for Recovering Access to Primary Care was published on 9 May 2023. The plan sets out two central aims:
  - to tackle the 8am rush and reduce the number of people struggling to contact their practice,
  - for patients to know on the day they contact their practice how their request will be managed.

- This is a two-year programme, incorporating four key areas to address the aforementioned aims:
  - implementing modern general practice access,
  - empowering patients to manage their own health
  - building capacity
  - cutting bureaucracy.

- This paper provides an overview of the plan and describes how we are working to implement the programme across North East London to enable local residents to see real improvements to their experience of accessing primary care, along with a summary of progress against the Delivery Checklist for ICBs, risks and mitigations.

National context

- Like many parts of the NHS, general practice is under intense pressure. Where demand is greater than capacity it means general practice cannot always be as effective, and patient experience and access are negatively impacted. It also means that stresses appear in other parts of the health and care system as patients seek alternative routes to get NHS care.

- Consequently, there remains significant focus on primary care, specifically in enabling improvements across primary care in terms of access, experience and outcomes. These ambitions are set out in the Fuller Stocktake Report and the Delivery Plan for Recovering Access To Primary Care.

- The Fuller Report built a broad consensus on the vision for integrating primary care with three essential elements: streamlining access to care and advice; providing more proactive, personalised care from a multidisciplinary team of professionals; and helping people stay well for longer. However, before we are able to fully implement the wider reforms necessary to achieve this vision, we need to take the pressure off general practice.

- The Access Recovery Plan sets out a commitment to tackle the 8am rush and make it easier and quicker for people to get the help they need from primary care, putting in a place a range of initiatives in four key areas.

Delivery Plan for Recovering Access To Primary Care

North East London Health & Care Partnership

- **Empowering patients** - *Tools for patients to manage own health using NHS App and community pharmacy expansion*
- **Implementing 'modern general practice access** – *Tackling the 8am rush so patients know on the day how request will be handled, respecting appointment type preferences*
- **Building Capacity** - *Practices can offer more appointments & add flexibility to the types of staff recruited and how they are deployed*
- **Cutting bureaucracy** - *Reducing workload across interface between primary and secondary care & medical evidence requests, so there is more time to focus on patients' clinical needs*

Primary Care Access Recovery Plan - local context

North East London Health & Care Partnership

- This is a broad ranging ambitious plan which requires action at both practice and Primary Care Network (PCN) level. However, delivery of the plan cannot be undertaken by primary care alone due to many interdependencies that span across portfolios and support from colleagues working in acute and community services is therefore required to ensure clear patient pathways are delivered Place. At every opportunity we will apply the principle of subsidiarity to enable decisions to be made as close to the population served as possible
- Delivery of the plan will enable a shared sense of vision to emerge, within each neighbourhood, acknowledging that different organisations have different cultures around risk and help foster a shared culture that puts the needs of residents first.
- The roll out of the plan will strengthen both general practice and primary care network (PCN) infrastructure, identifying opportunities to employ a workforce that has the right skill mix to meet the need of local communities within a neighborhood offering. A Personalised Care approach at the front line of general practice will enable a much clearer identification of the needs of patients who require the most support with access and continuity of care. This will also free up capacity to support these patients by making the best use of digital tools for those patients who can use them
- Central to the success in the delivery of the plan will be the work required with local people to improve their experience when accessing primary care services.
- Data shows that the rate of appointments in NEL has increased over the past year by 5.3%, and we are on track to meet our Operating Plan trajectory for increasing the number of appointments. Despite this, the 2023 GP Patient Survey shows that although the majority of local residents who responded to the survey said that their needs were met by the healthcare professional at their last appointment, they also reported a less positive experience when trying to make an appointment.

Increasing productivity

North East London Health & Care Partnership

- Increases in appointment activity can be seen across all NEL places with the average rate of appointments per 1000 patients increasing by 5.3%.
- The results from the GP patient survey continue to evidence that delivering more appointments does not automatically result in better patient experience. There is no correlation seen between patient satisfaction and rate of appointments, which suggests that increased appointment volume does not automatically result in better patient experience
- Offering a Personalised Care approach at the front line of general practice will enable a much clearer dentification of the needs of patients who require the most support with access and continued care. This will also free up capacity to support these patients by making the best use of digital tools for those patients who can use them.
- NEL is participating in a Londonwide deliberative exercise to understand the diverse and different needs of the population, focussed on personalisation, integration of care and single point of access.
- Further exploration to understand the variation that exists between different Primary Care Networks across NEL. The Patient Survey results will be viewed alongside other measures of patient experience to build a balanced picture of the impact of the Plan. A focus on unwarranted variation will identify practices who may need additional support, and enable learning from practices who are providing high-quality access.

Average weekly appointment rate per 1000 registered patients (January to July) comparison

Borough/Place	2022	2023	Change (%)
Barking and Dagenham	78.0	85.6	9.8%
City and Hackney	95.2	101.3	6.5%
Havering	72.8	78.9	8.3%
Newham	76.0	79.3	4.4%
Redbridge	80.0	85.2	6.4%
Tower Hamlets	93.5	94.2	0.8%
Waltham Forest	76.9	79.9	3.8%
NEL	82.0	86.4	5.3%

Total appointment count (January to July) comparison

Borough/Place	2022	2023	Change (%)
Barking and Dagenham	603,144	676,188	12.1%
City and Hackney	995,679	1,078,134	8.3%
Havering	647,435	712,272	10.0%
Newham	1,052,858	1,134,583	7.8%
Redbridge	867,652	951,348	9.6%
Tower Hamlets	1,092,285	1,119,642	2.5%
Waltham Forest	777,416	795,168	2.3%
NEL	6,036,469	6,467,335	7.1%

Source: GP Appointments Data (GPAD)

What will Access Recovery Plan mean for local residents?

North East London Health & Care Partnership

Our ultimate goal is that delivery of the plan will mean that NEL residents will see a difference in the way they access services and the way services respond to their needs.

Their calls will be handled through a queuing system and then answered or a call back offered

Their requests will be managed on the day rather than having to call back on a different day.

They will have access to more services from their local community pharmacy such getting a prescription for a range of conditions that they could previously only get from their GP

They will be able to access some healthcare professionals directly without needing a GP appointment first eg community physiotherapy

They will see a wider range of health care professionals to better meet their own particular needs

They will be able to use the NHS App to view their GP records and access a range of NHS services, for example appointments, clinic letters, test results and care plans

Developing a Strategic Plan for Workforce

North East London Health & Care Partnership

Making the best use of our Workforce is critical to delivering access to modern general practice. Staff working at the frontline of general practice will be supported with training needs assessments. Each PCN will be supported to develop 5 year plans that will include targeting areas for priority intervention focused upon recruitment and retention. We are proposing the establishment of three workstreams to develop strategic plans which identify the workforce, training and educational needs that will enable us to recruit and retain primary care nurses, GPs and the wider workforce.

GP Recruitment and Retention- new Group	Primary Care Nursing -established	Neighbourhood and Network Development - new
• Clinically led • Place representatives for the profession • Employer Representatives • Training Hub, Clinical lead and Management representative • Primary Care Directorate and PCN leadership	• Clinically led • Place representatives for the profession • Employer Representatives • Training Hub, Clinical lead and Management representative • Primary Care Directorate and PCN leadership	• Led by Fuller People workstream/ PC Delivery • PCN leadership • Service lead representation • Professional leadership (Allied Health Professionals, Pharmacists etc) • Training Hub, Clinical lead and Management representative

ICB Primary Care development team to lead Engagement with Local Partners (incl training hubs)

BHR local delivery x3

CH local delivery

Newham local delivery

WF local delivery

TH local delivery

Primary care teams and training hubs will lead local delivery at place as part of partnership working with local providers including the voluntary sector

Governance and delivery

North East London Health & Care Partnership

- The Primary Care Delivery Group has executive oversight of the programme, reporting to the Primary Care Collaborative. The Delivery Group membership includes Place based Primary Care Clinical leads who will act as the interface into local Place Delivery Groups. Progress against specific components of the programme will also be reviewed in the urgent and emergency care and planned care programme boards.
- The ICS's Clinical Advisory Group (CAG) will devote a session every 4-6 weeks to provide strategic oversight to improving the primary-secondary care interface, and will reach into the acute and community collaboratives to enable this work.
- Local interface groups will sit alongside this session at CAG to ensure a two-way discussion between the NEL and Place governance as well as implementing delivery at Place. This session of CAG will act to identify and solve current and upcoming system interface challenges between primary and secondary care, strengthening relations, improving communication, developing new integrated pathways, ensuring interface processes meet the needs of all. Projects with named leadership to cover the key areas, will be scoped by January 2024.
- NHSE has developed a checklist of actions to enable ICBs to assess progress against the four commitments of the plan. Each action in the checklist has an owner and is attributed to a specific programme with progress captured within a programme report. The latest self-assessment for NEL ICB can be found in Appendix A.
- Every GP practice/PCN in NEL will need to play a role in delivery of the plan. In order to assess progress and impact, a toolkit has been disseminated based on the NHSE checklist of actions. The toolkit will be used to understand progress, the support needs of practices and to identify where further supportive discussions with individual practices need to take place. We expect this analysis to be fully completed by the end of November 2023.

Health inequalities

North East London Health & Care Partnership

- An Equalities and Health Impact Assessment was undertaken to assess potential positive or adverse impact of the programme for protected characteristic groups and potential positive or adverse impact for people who experience health inequalities. The assessment did not identify any negative impacts, instead the programme brings a positive or neutral impact to these groups.

- The programme will equalise local people's access to digital tools by all practices and primary care networks making use of these. Making best use of digital tools will reduce the volume of calls overall, and use of digital tools by those patients that can use them, will help to free up practice capacity to focus on those patients that are unable to use digital routes or need the most support in accessing primary care. It is recognised that there is no one single way to deliver good access and patient experience.

- Practices will need the flexibility to develop systems and processes that best meet the needs of their patients. By using their understanding of their local population needs and inequalities, they will be able to direct resources and focus in the most appropriate way. It is important that practices keep this under continuous review as this is a constant dynamic process that requires adapting according to changing local population needs and available resources.

- The GP Patient Survey (GPPS) results will be viewed alongside other quality metrics to build a balanced picture of how practices and PCN are operating. A focus on variation will identify practices who may need additional support, and enable learning from practices who are providing high-quality access.

Finance

- In order to maximise value from national and local funding to support the delivery of this plan, the ICB is working to ensure robust plans are in place for the Capacity and Access Improvement payments, transitional funding to support to the move to modern general practice access and funding to support practices to move to cloud based telephony.

- We will ensure that practices and PCNs receive funding in a timely way and monitor and track this to ensure that funding is spent in-year (see Appendix A).

- System Development Funding is being used to support workforce, pharmacy and digital initiatives which will also help to deliver the plan.

- Practices are also being encouraged to participate in nationally funded training and development offers such as the GP Improvement Programme and care navigation training.

Communications and Engagement

North East London Health & Care Partnership

To date, we have undertaken engagement and insight work in the following areas:

- Over 1,500 residents from across NEL shared feedback in a London-wide engagement exercise over the summer on their experience and understanding of the digital tools available to help them access primary care services. This insight will be used to further inform work on how we improve local people's understanding and take-up of digital tools to access primary care.
- Almost 40,000 residents across NEL gave feedback on routine evening and weekend GP appointments. This valuable insight has been shared with all PCNs and primary care leads, and was used to inform local service models for enhanced access, as well as ongoing work to plan future estates developments and service changes.
- Resident insight gathered from a range of local engagement work by the ICB, Healthwatch and other local NHS and Council partners has informed our 'Right Care' campaign, aimed at supporting local people to access care when they need urgent same-day care. The campaign will run for 12 months from November 2023 and is focused on building public understanding and confidence in how to access primary care services . It will be targeting demographic groups most likely to attend A&E when they could be seen elsewhere, or those who could be vulnerable to preventable hospital admissions. Activity will consist of a mix of targeted digital advertising, outdoor advertising, press, social media, and partner communications.
- We are also piloting new Winter Wellness guides in Havering, Tower Hamlets and City and Hackney aimed at helping vulnerable and older adults stay well over winter with wholistic information on health and care services, cost of living support, winter vaccinations, GP services and the range of health professionals within primary care. These guides were co-designed with local residents
- The ICB is also scoping engagement work to take place during the winter to further explore digital hesitancy, with the aim of gathering proposals for how we better support local people to feel confident and able to use digital tools. We are mindful of the local challenge within North East London of digital poverty and exclusion, and this will continue to be explored through ongoing partnership work.

Communications and Engagement

North East London Health & Care Partnership

Looking ahead, there will be further and ongoing engagement on patient experience, focusing on access to appointments and understanding of digital tools, ensuring clarity of messaging around access to new models of general practice care:

- Understanding the role of reception teams – to build understanding that residents should expect to be asked the reason for their request, by trained reception teams. This is essential information so that their needs can be met by the right person or service, with the least number of steps, in the shortest time.
- The GP is not the only person who can help. They are part of a wider team of highly skilled and trained professionals including community pharmacists, optometrists, physiotherapists, social prescribers and mental health practitioners.
- Whilst face-to-face GP appointments are used for over half of patient encounters, online consultations and telephone consultations are often the best and most convenient way of accessing care.
- Identification at practice level of the needs of patients who require the most support with accessing care. And freeing up capacity to support these patients by making the best use of digital tools for those patients who can use them.
- Develop the structure of patient participation groups (at practice and PCN level) to enable co-production of improvement work and tackling health inequalities.

GP Patient Survey data together with other forms of feedback such as Complaints data, The Big Conversation, ongoing insight gathering from residents and VCS partners such as Healthwatch, and GP appointment data will be used by the ICB to inform our planning, quality improvement work, communications and engagement and enable us to assess whether we have achieved our ambition to ensure that local residents will experience a real difference in the way they access primary care services and the way that these services respond to their needs.

Conclusion

- In conclusion, the ICB can demonstrate good progress towards the national access recovery plan requirements.

- Next steps include:
  - further engagement on patient experience
  - using the analysis from the GP Toolkits to inform place-based prioritisation of support
  - developing the workstreams to improve the interface between primary and secondary care
  - making best use of national Pharmacy contractual changes to build on the considerable advances already made across NEL.

NHS
North East London

Appendix A

Delivery Plan for Recovering Access to Primary Care

Progress against ICB Actions checklist as at October 23

Key

- Not on track
- On track
- In place/completed

Progress against key milestones – Empowering Patients (1/2)

North East London Health & Care

Initiative	Description	Target	Update	Risk/Mitigations	RAG
Self-referral pathways	Establish all self-referral pathways (including MSK, audiology and podiatry) as set out in 23/24 guidance, also ensure pathways are in place between community optometrists and ophthalmologists	Expansion of self-referral pathways September 2023	Task and Finish Group in place to provide oversight. Progress made with some variability between the different pathways. There is an ambition to reach 100% self-referrals into these seven services. A two-phased plan in place to increase access and improve self-referral pathways. • Phase1: to improve digital capability to increase uptake • Phase 2: review of all existing service contracts and pathways to ensure that self-referral is contractually mandated with providers. Referral pathways are in place between **community optometrists and ophthalmologists.** **Wheel chair services:** Partially in place in all places. Planning to develop further. **Community equipment services**: In place in BHR. Other places refer by prescribers. **Falls services**: In place in most in most of NEL but not in Tower Hamlets. **Weight management services**: In all Places bar Redbridge **Audiology services**: Not yet in place. Stakeholder reviewing impact. Roll out to be completed by April 25. **Podiatry** services: Not yet in place. Stakeholders reviewing clinical pathways. **MSK*:*** Partially in place. Self-referral to form part of new service model to be rolled out and completed by April '25.	Increased demand from patients not high risk. These cases will require triage and sign-posting to appropriate services. Multiple providers incl. independents. Developing an understanding of provisions and capacity for the referrals to be managed within resources. Some self-referrals might lead to lower quality of referrals and impact on lead in time. To be managed through codesign. Risk of cost pressures. Working with providers to understand plans to roll out self-referrals. Resource risks around being able to deliver the improvements to digital pathways and contract changes	
Prospective records access	Apply system changes or manually update patient settings to provide prospective record access to all patients	31 Oct 2023	Task and Finish Group in place to oversee this. Currently 60% of practices are enabled to share records, which is in line with the national position of 61%. GP IT Facilitators working with targeted practices. ;Getting Ready' Webinars have been be held. Work being undertaken to support the remaining practices to undertaken the necessary steps to allow prospective records access,	Limited dates for EMIS to bulk upload practices. Practices supported to submit opt in form to allow EMIS to bulk upload their records. Practices targeted within NEL by the GP IT team to ensure the deadlines met.	

Progress against key milestones – Empowering Patients (2/2)

North East London Health & Care

Initiative	Description	Target	Update	Risk/Mitigations	RAG
Community Pharmacy	Support the expansion of community Pharmacy services (including oral contraceptive and blood pressure services)	Ongoing	Community pharmacy; Since April 22 NEL ICB has funded holistic Community Pharmacy Consultation Service (CPCS) implementation support for Practice and Community Pharmacy teams This includes an integrated referral solution for Emis that allows GPs to send CPCS referrals to local pharmacies directly. As a direct result of this support, NEL has the highest level of CPCS referrals from GP in the country. Discussions are taking place with hospital leads in activating the Urgent and Emergency Care (UEC) minor illness referrals to CPCS in anticipation of the launch of the National Common Conditions Service (CCS). It is expected that national antimicrobial resistance (AMR) leads will have shaped the processes for issuing medicines appropriately under the CCS. The ICB will ensure, where appropriate, the antimicrobials deployed are compliant with local guidance. NEL ICB is funding holistic blood pressure (BP) and oral contraception services (OC). This includes an integrated referral solution for EMIS that allows GPs to send BP referrals to local pharmacies directly. As a direct result of this support, NEL has the highest level of BP referrals from GP to Community Pharmacies in the country.	Expansion of these services is dependent upon national negotiations between Community Pharmacy England (CPE) and NHSE. ICB are putting preparation in place in good time, so that we are ready to have local services in place once national negotiations are concluded and new services are launched.	

Progress against key milestones – Moving to modern general practice (1/2)

Initiative	Description	Target	Update	Risk/mitigations	RAG
Telephony	Practices which have signed-up ready to move from analogue to digital telephony – switch off analogue in March 2024	July 2023 Switch off March 2024	All 60 practices that are on analogue are being supported to move to cloud based telephony. On track for March switch off. Some practices may move later in 2024 to reduce cost of early contract ceasing	Risk that not all practices will move on time. Funding and support provided. Plans incorporated in PCN CAP Plans	
Training	Nominate PCNs / practices for national intensive and intermediate transformation support through the GP Improvement Programme	2023/24 rolling programme	National Prog: 11 practices signed up so far for the 16 and 32 week programmes. Local Demand and Capacity training: 31 have undertaken this with 17 more due to undertake this. Practices that have been on the programme have had Support Level Framework discussions.	Reluctance of practices to sign up due to capacity issues. Practices that would benefit most being targeted. Backfill support to be provided through transitional funding. Local training offers available and flexing round practice availability,.	
Navigator training	Co-ordinate nominations and allocations to care navigator training, and digital and transformation PCN leads training and leadership improvement training	2023/24 rolling programme	National prog: 95 NEL practice staff engaged in care navigation foundation and advanced programmes Local:158 attendees at signposting training run locally by Equip Team 58 attendees at local patient triage comms training	Actively encouraging practices to sign up through regular communication updates on training and through Place teams having conversations with practices and prompts in the toolkit issued in September. Local training also available	
Transitional Funding	Agree to distribution of funding to qualifying practices to develop modern general practice	Oct/Dec 2023	Local policy/process agreed and rolled out to practices. Practices to submit plans by 31 Dec 23. Plans to be assessed and 50% to be paid in 22/23 on approval and 50% to be paid in 23/24 on completion.	We receive funding in 22/23 and 23/24 and it has to be spent in-year, therefore funding to be allocated to practices on a 50/50 split in both years All plans to be reviewed and approved to ensure appropriate use of funds.	

Progress against key milestones – Modernising general practice cont (2/2)

North East London Health & Care Partnership

Initiative	Description	Target	Update	Risks and mitigations	RAG
IIF / CAIP funding	Understand and sign off PCN/practice capacity and access IIF CAIP baseline using guidance and Annex B template	All 47 PCNs	Data shared and plans for 47 PCNs agreed. These focus on patient experience of access, ease of access and demand management and accuracy of recording in appt books. Practices to submit a report on progress against plans in May 24 and reports to be assessed to inform payment of improvement payments by Aug 24..	Risk that practices won't deliver on plans by year end. Place teams liaising with PCNs to ensure delivery.	
Support needs	Practice to benchmark progress and identify support needs (digital telephony, online tools, training, capacity backfill, intensive support, etc) in local Practice Access Plan Toolkit	End Oct	Toolkits disseminated and being returned. Collation and analysis in Oct/Nov 23.	Risk that practices won't all complete toolkit Place teams to support practices to complete where necessary. Completion of toolkit linked to access to transitional funding	
Digital Tools	Select digital tools from the Digital Care Services Framework (DCSF). These are planned: EMIS Web clinical system; TPP SystmOne; Eclipse prescribing s/w AccuRx (Floreys, SMS plus, batch SMS) Online / video consultation; AccuBook Edenbridge Apex; SMS fragments	(Framework due January 2024)	OCVC costs incurred by the ICB to date are being recovered from DCSF funds held on behalf of ICB. Discussions underway with GPIT team to agree way forward for further purchases. If already on digital telephony, ensuring call-back functionality & queuing enabled.	OCVC funding being mitigated before DCSF is live by liaising with procurement hub	

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Progress against key milestones

Building capacity

Initiative	Description	Target	Update	Risks and mitigations	RAG
ARRS	Support PCNs to use their full ARRS budget and report accurate complement of staff using NWRS portal	2023/24	Support to PCNs being provided through workforce and place teams. The ICB is working with each Place to develop Primary Care Forward Plans that consider the need to grow and develop their GP workforce in order to deliver the access improvement.	Ensure close monitoring of spend and year-end forecasting. Monthly group set up to triangulate information between teams.	

Reducing bureaucracy

Initiative	Description	Target	Update	Risks and mitigations	RAG
1º- 2º interface	Plan for improving the primary–secondary care interface, onward referrals, fit notes, call recall clear points of contact.	2023/24. Board update	Establishment of an overarching Interface Steering Group, linking to CAG and acute and provider collaboratives with local interface groups feeding into it.	There are a large number of interface issues that need addressing across NEL and the places. Ensure governances structures and capacity in place to oversee this work over the next two years	
GP Registration	Support practices to sign up to the 'Register with a GP Services'	Dec 23	Over the past few years, NEL has pioneered an easy to use online GP registration service and all NEL residents can access this service. This has now been rolled out nationally.	Ensure all practices use the service and advertise to new patients. Assessment is taking place on this through the toolkit.	

NHS
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NEL Integrated Care Board Urgent and Emergency Care Recovery Plan

November 2023

Urgent and Emergency Care Recovery Plan

North East London Health & Care Partnership

The National UEC Recovery Plan was published by NHSE and DHSC in January 2023, setting out commitments to improve waiting times and patient experience by:

The UEC Recovery Plan includes key performance ambitions for the next two years

- **Patients being seen more quickly in emergency departments:** with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.
- **Ambulances getting to patients quicker:** with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.
- **Reduce 12 hour waits** from time of arrival in Eds (maximum threshold of 2% of patients waiting longer than 12 hours In emergency departments.
- **Reduce bed occupancy** to the 92% level which is safer and more efficient enabling a healthy flow through hospitals, this is enabled by admission avoidance, and alternative pathways of care including virtual ward. Reduced bed occupancy also enables the delivery of the 4 and 12 hour wait and offloading of ambulances.

- North East London ICS has agreed a **single point of focus** for our UEC improvement work, responding to all Regionally and Nationally mandated plans and assurance including
  - National Tier 1 reporting- North East London (NEL) ICB has been categorised as a Tier 1 system as a result of an NHSE assessment against the priorities in the UEC Recovery Plan.
  - National UEC Recovery Plan- delivering the priorities, benefiting our population, patients and workforce.
  - Winter plan- Winter planning across the system has been informed by the national approach outlined in the NHSE winter guidance (published in July 2023), including the importance of mobilising additional capacity across all parts of the NHS, delivery of the ten high impact interventions, effective system working and supporting our workforce.

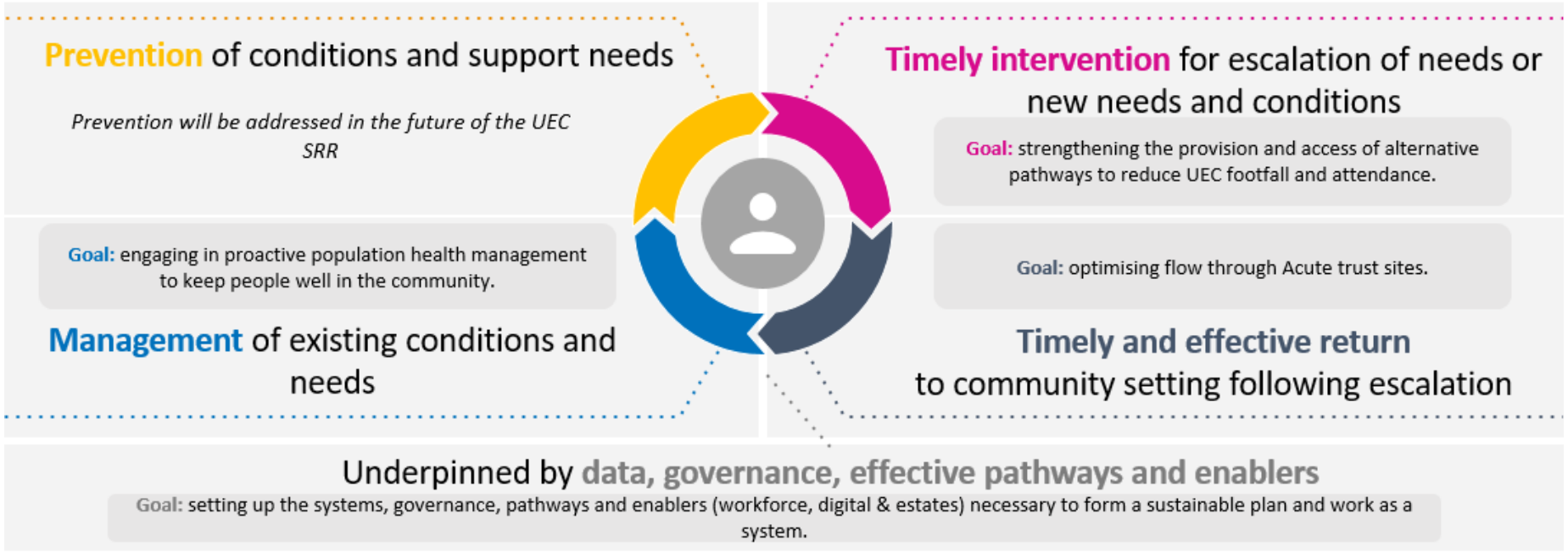
Our system ambition for UEC

A System Resilience Review was conducted in spring 2023, providing a comprehensive overview of opportunities to deliver system resilience ahead of winter as well as look for long-term transformational opportunities and future governance of single system-wide UEC improvement.

The UEC Recovery and Transformation Portfolio has subsequently been established in October 2023. The portfolio is focused on the tactical and strategic opportunities over the next 2 years that continues to align to the priorities to the system partners and the Joint Forward Plan. This will build and sustain a UEC system that keeps people well, meets the health needs of the population, ensures easy access to care where required in the community, with efficient flow through acute care when required, that is supported by a workforce that operates without being overwhelmed.

The graphic below articulates the vision, strategic system goals and outcomes of the UEC Recovery and Transformation Portfolio:

UEC vision: Improved access to urgent and emergency care for local people that meets their needs and is aligned with the national UEC Recovery Plan



Outcomes delivered by UEC vision and goals

- Strengthening the provision and access of alternative pathways to reduce UEC footfall and attendance
- Optimising flow through Acute trust sites
- Engaging in proactive population health management to keep people well in the community
- Setting up the systems, governance, and pathways necessary to form a sustainable plan and work as a system

UEC key programmes of work

North East London Health & Care Partnership

The key UEC programmes of work have been identified to address challenges in and out of hospital:

Winter planning

- Winter planning is in its final stages through place and partners.
- Capacity planning has been completed including virtual wards, SDEC and alternative pathways of care
- Waterfall analysis has been developed linked to demand and capacity plans

Mental health in ED & Flow

- Mental health attendance and long waits in emergency departments remains challenging despite a comprehensive plan
- The Mental Health Collaborative with acute partners have commenced a number of pilot schemes to add to crisis management and attendance and admissions prevention
- Exploring “discharge ready in Mental Health”
- MH System Improvement Team working with and advising the system on additional opportunities for improvement

Flow and alternative pathways

- Optimising admission avoidance through SDEC using case-mix review through NHSE
- Optimise discharge processes including discharge ready
- Further reduce 12 hour waits in ED both physical and mental health
- Optimise use of virtual care and pathways at place and NEL level.

Type 3 – UTC & Same Day Access

- The system has completed a review of the Urgent Treatment Centres performance at BHRUT and Bart’s to improve performance against the 4 hour standard
- This is currently at 77% NEL with an ambition to deliver at > 95% in Q4
- Long term planning as part of the Same Day Access and Fuller

Ambulance conveyances / system clinical coordination

- Implementation of maximum 45 min ambulance handover standard from 26 July has seen a significant improvement for 30 and 60 minute offloading of patients, and releasing fleet back into the community
- Next steps: Cat 2 response time (improved but remains statistically low)
- REACH optimisation, including extension to direct to SDECs, and single point of access

In order to achieve the vision and goals set out in the previous slide and the key programmes of work, the NEL UEC PMO has been established and is being developed throughout Q3 and Q4 23/24. The PMO will support the UEC Recovery and Transformation Portfolio to:

- **support local teams to deliver improvements** aligned with the UEC recovery plan ambitions
- promote **partnership working and collaboration –** right care, first time-Continuing to empower partners to deliver programmes of work as close to patients, clients, service users and our population as a key and sustainable principle**.**
- ensure **alignment with the ICS joint forward planning and other NEL portfolios** including mental health, community and primary care
- respond to **regional and nationally mandated plans and assurance**

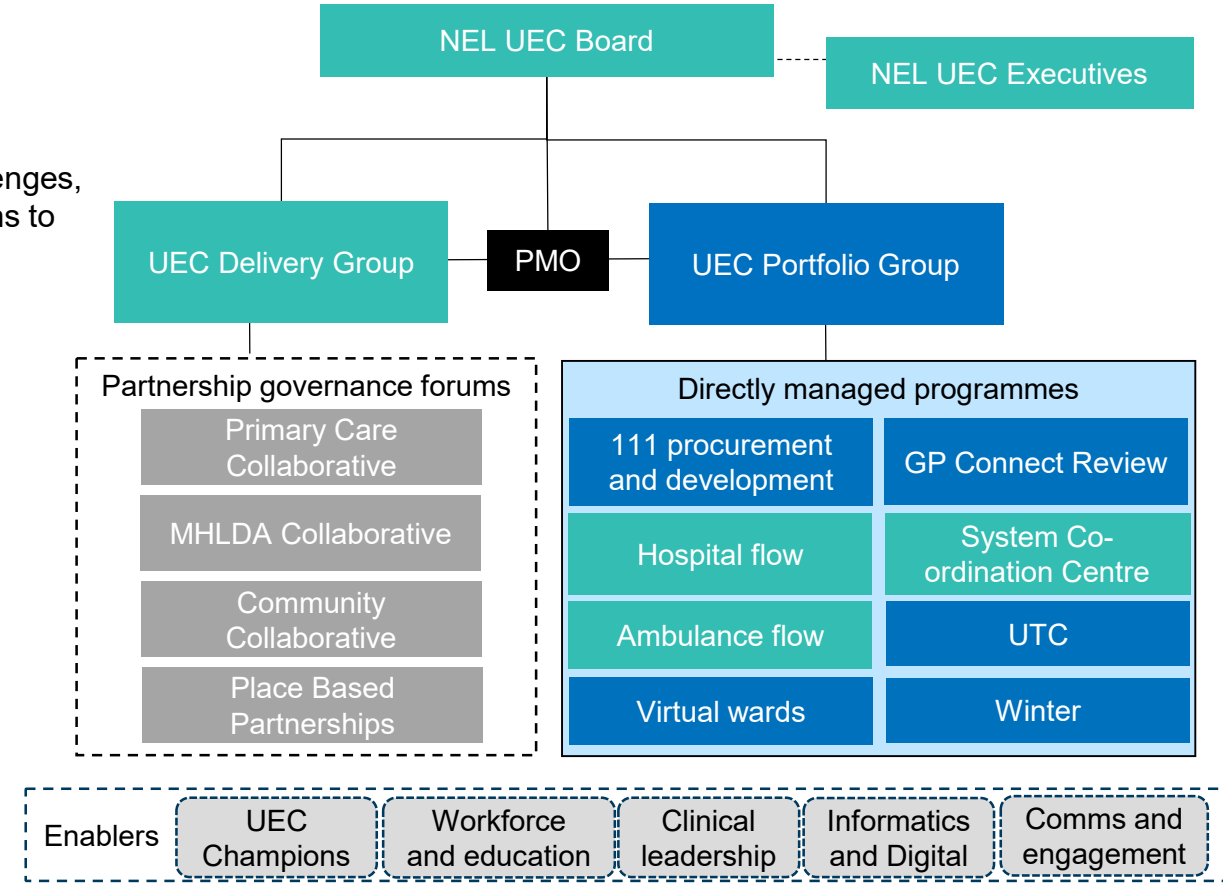
UEC governance

Our governance is being designed around teams working in partnership with each at the following levels:

- **Places:** delivering services and improvement for Neighbourhoods and Place;
- **Collaboratives:** reducing unwarranted variation, driving efficiency and building greater equity; and
- **NEL:** sharing best practice, implementing NEL solutions for system-wide challenges, providing programmatic support and oversight, and delivering enabling functions to our organisation and ICS through a business partner model.

UEC governance principles

- The portfolio will be aligned and connected to improvement work already underway and led by our Place Based Partnerships, Provider Collaboratives and other NEL portfolios.
- The portfolio will encompass a significant operational focus as well as transformation and improvement work to address the challenges in the UEC Recovery Plan.
- Clinical leadership, data, digital solutions and workforce are key cornerstones of our ongoing portfolio development and implementation.
- Proactive identification and management of risks and issues through coordinated risk and escalation processes.
- Delivery of individual improvement projects is overseen by Place Based Partnerships and Provider Collaboratives.
- Embedding High Impact Interventions and Universal Support Offer as part of our winter and improvement planning.



*** Please note that the UEC governance is being refreshed and the structure provided is currently under review**

Key: UEC transformation | UEC transformation & ops | Dependency-led

Successes to date

North East London Health & Care Partnership

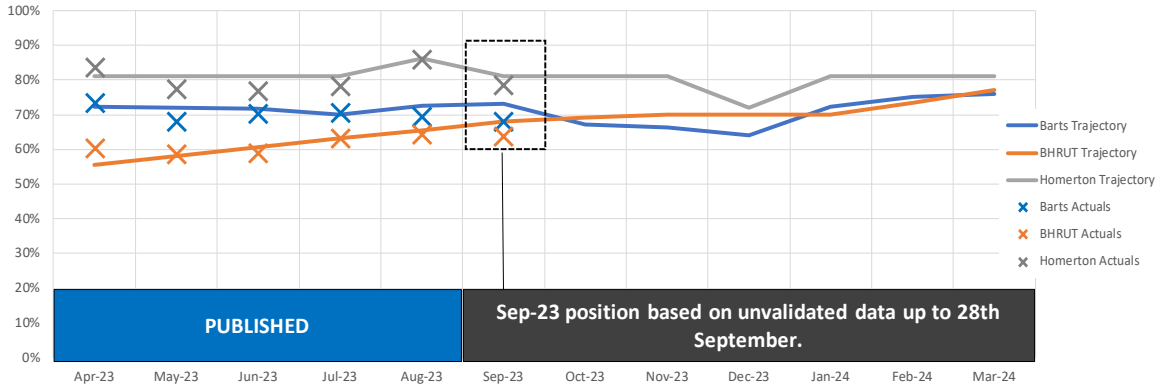
Despite the UEC Recovery and Transformation Portfolio being in its infancy, there have already been a number of successes made:

- **Establishing the UEC portfolio team**: The Interim Director of UEC was appointed in July 2023 and a small interim team has been stood up to support the transformation priorities from October 2023.
- **Robust winter planning** has been undertaken with providers, places and collaboratives, including the System Resilience Review, place and hospital-based winter plans, demand and capacity modelling, NHSE assurance submissions, launch of the NEL winter communications campaign and a system-wide Winter Planning Collaborative Event held in October 2023.
- **Programmes of work have been initiated** to align with the immediate priorities outlined on slide 4
- **Partnership working** with providers, places, collaboratives and NEL portfolios including mental health, primary care and community
- **Collaboration linking pathways to prevent unnecessary A&E attendances** including the Fuller programme
- **Advances with digital innovation** including an innovative programme on health navigation that will enable us to monitor people in the community and predict when they will need to come into hospital and implementation of virtual care programmes
- **Ongoing UTC review** working with UTC providers to develop action plans to continue to improve performance and productivity
- **Establishment of the Ambulance Optimisation Working Group** that focuses on performance and transformation of service
- Preparations for the launch of the **System Co-ordination Centre (SCC)** are currently on track to meet the 91% compliance target for 6 December
- **Tier 1 support** within Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) is delivering significant improvements in Type 1 and Type 3 performance, discharge ready and increased use of SDEC
- **Securing access to funding for improvement planning** including following through on capacity plans that were done at the start of the planning round in 23/24 and linking this with the ongoing transformation priorities

UEC performance- where are we now against the National Priorities

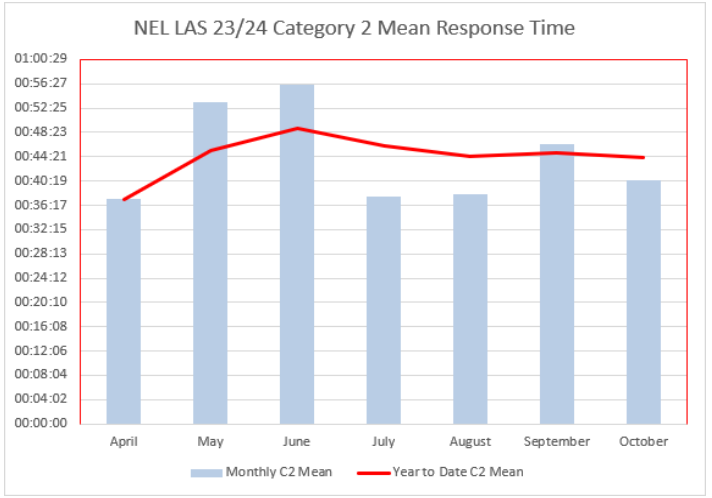
The following charts provide an overview of the September 2023 NEL position against the core metrics for the UEC Recovery and Transformation Portfolio. These metrics are aligned to our transformation priorities outlined on slide 4.

A&E 4 hour performance (all type)



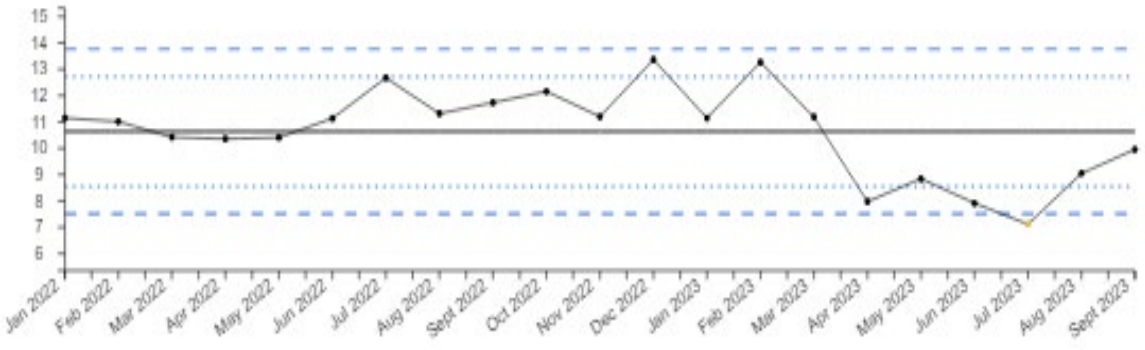
- NEL ICS reported 68.4% all type performance against a plan of 72.6% plan in September and year to date 68.36%
- All types performance in September was Type 1 60.1% and Type 3 at 80.2%

Category 2 ambulance offloads



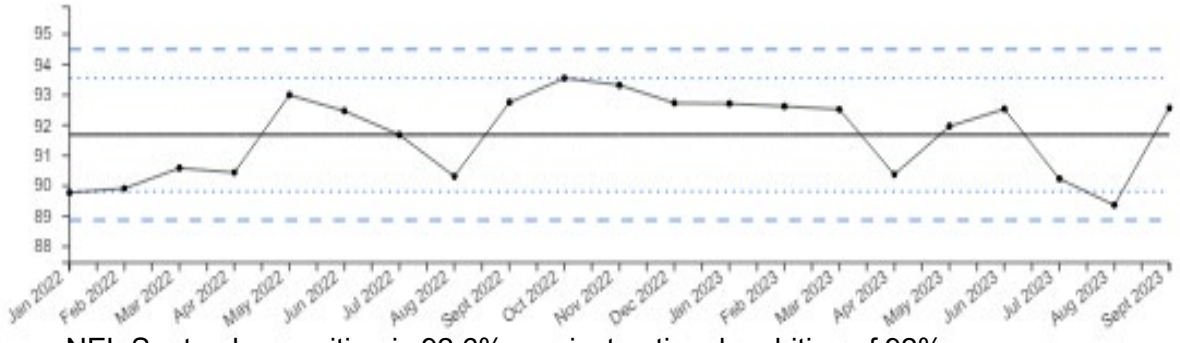
- 67% of patients were offloaded in 30 minutes and 99% of patients were offloaded within 60 minutes
- Category 2 ambulance response at 40 minutes year to date average
- Since the implementation of W45 in July 2023, North East London have the second lowest conveyance rates to hospital of 48% the highest rate in London
- .

% waiting over 12 hours from arrival to departure



- 10% of the attendances were waiting over 12 hours from arrival to departure across NEL
- The National plan is no more than 2% of all patients waiting 12 hours or more

G&A bed occupancy



- NEL September position is 92.6%, against national ambition of 92%
- We are working on additional plans including further development of virtual wards, development of SDEC and other pathways to reduce acute bed occupancy

Programme risks, mitigations and next steps

North East London Health & Care Partnership

Theme	Risk	Mitigation
Scope	There is a risk to delivery as a result of the complexity of UEC and the need to balance the operational, transformation and strategic priorities	• Refresh of existing UEC governance to ensure there is a robust approach that balances tactical and strategic priorities, including clinical governance • Enabling decision making as close to the patient as possible • Development of clear roles and responsibilities • Alignment and synergy with wider NEL portfolios and focus on partnership working
Resource	There is a risk that the ambitions of the UEC recovery plan cannot be delivered as a result of the lack of resource in the NEL UEC portfolio team beyond Mar-24	• Recruited small interim team until March 2024 • Deep dive review being undertaken with ICS CEC on 30 November to review resource requirement beyond March 2024 • Specific focus on recruitment of a SME resource on flow • Continue to establish effective processes and systems within the UEC PMO that will support the development of the team beyond Mar-24
Winter	There is a risk that demand outweighs planned capacity over winter resulting in impact to capacity, flow and patient & staff experience	• Capacity modelling reviewed as part of the national NHSE return for winter capacity in November • Focus on prevention, proactive care and keeping people well at home as core element of the Winter Plans engaging with wide range of partners • Strong governance and system working groups at Place and NEL integrated with wider UEC portfolio • Agile decision making on spend where required, including new bids for intermediate and POC capacity over winter 23/24 • Dynamic communications plan, with hyper local engagement • Winter Planning Collaborative Event held in October and have reviewed through a check and support process
System Co-ordination Centre (SCC)	There is a risk to the launch of the SCC as a result of staffing challenges and the need to complete consultation process to transfer staff from another provider	• Programme lead now in post as of 6 November • Recruitment plan including TUPE transfer of staff from NCL surge team • Currently on track to meet 91% compliance target by 06/12 including SOPs, data inputs and flows and infrastructure • Working closely with previous Surge Hub provider to ensure staff can be transferred at the earliest opportunity

<u>The UEC Recovery and Transformation Portfolio will continue to</u>:

- develop plans for 24/25 through the **Joint Forward Plan** process across NEL, including alignment with other portfolios;
- develop a consistent and **comprehensive UEC data set** with our digital colleagues;
- ensure robust **clinical leadership** for UEC across the system; and
- identify opportunities for **digital innovation.**
- Build on our plans to further develop our **workforce.**
- Align our transformation work using **QI methodology.**

NHS
North East London

Elective Recovery Plan

Executive Summary

The NHS delivery plan for tackling the COVID-19 backlog in elective care was published in February 2022. This plan set out the ambition to reduce elective care waiting times over a 3-year period by increasing levels of activity, transforming service provision and creating new capacity to ensure the NHS can provide resilient and sustainable elective care services.

The purpose of this paper is to provide the NEL Integrated Care Board with an overview of how the elective recovery plan is being delivered across North East London through the Planned Care Recovery and Transformation Programme and to report progress against the national ambitions to reduce waiting times.

Our Planned Care Recovery and Transformation Programme was formally established in September 2021 and has been developed over the last two years to reflect changing national, regional and local context. It is an integrated system programme which aims to improve equity of access in planned care and brings together system partners to collaborate across the entire planned care pathway – pre-referral, diagnostics, outpatients and surgical intervention. The structure and governance of the programme are summarised alongside the transformation priorities in outpatient & out of hospital care; diagnostic recovery and transformation and surgical optimisation.

The National Elective Recovery Plan

North East London Health & Care Partnership

- The NHS delivery plan for tackling the COVID-19 backlog in elective care was published in February 2022. It set an ambition to reduce the length of time people wait for elective care, over a 3-year period as follows:-
  - By July 2022, no waits over two years (104 weeks)
  - By April 2023 no one waits 18 months (78 weeks)
  - By March 2024 no one waits 15 months (65 weeks)
  - By March 2025 no one waits over a year (52 weeks)
  - By March 2025, 95% of patients needing a diagnostic test should receive this within 6 weeks (the DM01 standard)

- The delivery plan also describes opportunities to expand capacity within the NHS and transform the delivery of elective care services:-
  - Increasing health service capacity through the expansion and separation of elective & diagnostic capacity including establishing surgical hubs and community diagnostic centres
  - Transforming the way outpatient services are delivered including increasing the availability of pre-hospital care; advice & guidance, patient-initiated follow-up and virtual consultations
  - Providing information and support to patients whilst they are waiting for care

Planned Care Recovery and Transformation in NEL

North East London Health & Care Partnership

Planned Care Recovery and Transformation in NEL is an integrated system approach to improving equity of access to planned care which brings together system partners to recover and transform elective care. The programme was formally established in September 2021 building on the collaborative approach to elective recovery that was initially stood by acute providers in July 2020 to restore elective activity after the 1st wave of the COVID-19 pandemic.

Our approach to elective recovery and transformation has developed over the last 2+ years to reflect changing context and national, regional and local priorities. The portfolio brings together the delivery of national priorities for elective care and the activities and interventions we have agreed in NEL to meet the national ambition. The immediate aim of the programme is to eliminate all waits over 52 weeks by March 2025 across NEL whilst at the same time addressing the variation in equity of access across our local system.

The portfolio of planned care recovery and transformation work spans the elective care pathway from pre-referral to treatment encompassing out of hospital services, outpatients, diagnostics and surgery. The Acute Provider Collaborative (APC) acts as system leader for the oversight and governance of the programme across the ICS. The portfolio of work is led by the System Director of Planned Care and her team.

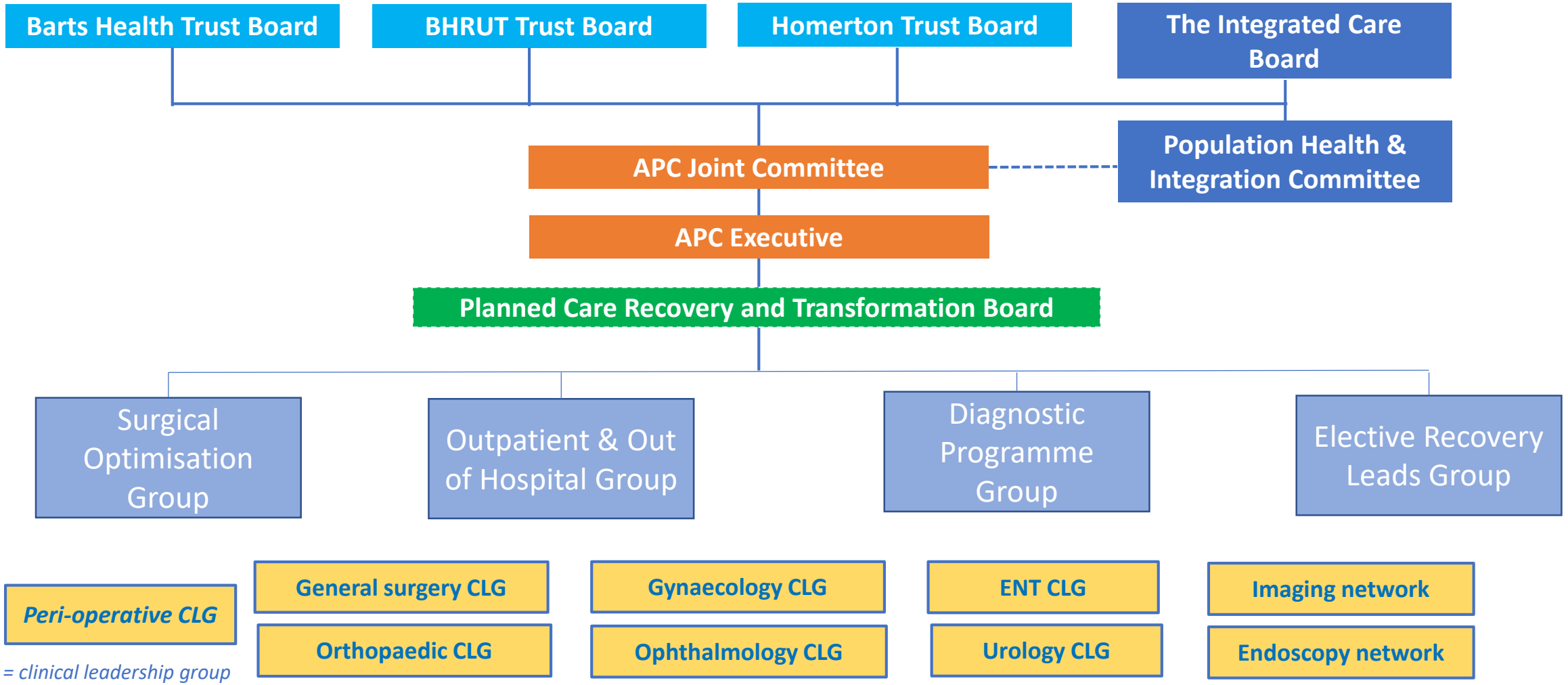
The NEL planned care team reflects the system wide approach to recovery and transformation with one integrated system team across the entire work programme. The team works with all system partners to create sustainable and resilient elective care services i.e. with primary care, placed based partnership and other provider collaboratives alongside the three acute providers.

Planned Care Recovery and Transformation 2023/24

An integrated system approach to improving equity of access to planned care for the people of North East London

Programme Aim	Key Drivers	Activities & Interventions	Commentary
To reduce waiting times for elective care in line with the national recovery plan so that no one is waiting more than 52 weeks by March 2025	Manage Demand	Waiting list management	Clinical prioritisation; validation; scheduling across the whole pathway (non admitted, diagnostic & admitted); Access policy
		Outpatient & out of hospital services	Virtual OP appt; A&G; PIFU; SPA; Primary/Secondary Care interface; community triage; community provision and supporting people to 'wait well'
	Optimise existing capacity	Collaborative Capacity	Using capacity collaboratively across the system to reduce variation in access times across NEL – diagnostics; endoscopy, surgical procedures (not LTC).
		Independent Sector	Making the most of available IS capacity to support non-admitted, diagnostic & admitted recovery? How do we reduce variation in access? APC plan for ISTC
		Productivity & Efficiency	Theatre efficiency & productivity; Diagnostic efficiency & productivity, GIRFT;
		Workforce	Identifying & addressing workforce gaps that limit are ability to optimise existing capacity e.g. anaesthetics; ODP; theatre nurses; radiographer; radiologists are required for new capacity
	Create new capacity	Community Diagnostic Hubs	Implementing CDCs at Barking & MEH. Plans for 3rd CDC. Development of ophthalmology diagnostics
		High volume surgical hubs	Implementation of 6 TIF theatres including agreement of speciality distribution to ensure capacity enables improvements in equity of access across NEL
		Digital Transformation	Using new technology to transform how we use our capacity and support transformation in the way in which we provide services

Planned Care Programme - Governance and Oversight



* CLG = clinical leadership group

Transforming Planned Care Services

North East London Health & Care Partnership

Outpatient & Out of Hospital Transformation

The aim of this programme is to optimise the use of our existing outpatient capacity whilst transforming how we work together across primary, community and secondary care to manage demand for services and create a sustainable outpatient & out of hospital system. Achieving this requires transformation across the whole pathway, as well as the way in which outpatient clinics are organised and delivered. Our programme of works includes:-

- Improving operational processes in outpatients – scheduling, DNA and cancellations
- Use referral optimisation tools (A&G/R) and employ digital solutions to improve primary/secondary care interface & management of demand
- Reduce non-value added follow up activity including increasing the use of PIFU
- Reduce variation in access to 'out of hospital' services across NEL that provide an alternative offer to people and reduce demand on secondary care services. Priorities areas include T&O (MSK), Gynae (Women's Health Hub), Ophthalmology, ENT and Dermatology .

Diagnostics Recovery & Transformation

The recovery and transformation of diagnostics includes a broad portfolio of work encompassing imaging, endoscopy, pathology and physiological measurement. The aim of the programme is to create resilient diagnostic services to support elective, including cancer, pathwaysThe portfolio of work in NEL includes

- Development and implementation of 3 CDC sites – Mile End, Barking & St Georges
- Leading re-procurement of GP direct access/community diagnostics across NEL alongside increasing, and reducing variation in, access to GP diagnostics and supporting the development of straight to test pathways.
- Supporting the development of nationally mandated networks in pathology, imaging, endoscopy and physiological measurement.

Surgical Optimisation

The focus of this programme is to ensure we are using our available elective surgical capacity to increase volumes of activity and reduce waiting times. This includes Trusts improving the utilisation of their elective theatre capacity and optimising the use of NHS and ISP capacity to reduce waiting times. NEL has secured @ £33m investment from the target investment fund to open new theatres in Hackney, Newham and Redbridge, which are expected to operate as system assets.

Successes to date

North East London Health & Care Partnership

- Since April 2021, around 10,000 people have received outpatient, diagnostic or surgical care in a different NHS hospital to the one to which they were referred. We continue to operate a collaborative capacity model across NEL with patients being offered the opportunity to transfer to an alternative provider with a shorter waiting time for first outpatient appointment.
- Secured capital and revenue funding for three CDCs in NEL. Full completion at Barking Community Hospital will be in January 2024 and Mile End Hospital full completion will be in July 2024. The 3rd CDC for St Georges Hospital has been approved with full opening set for summer 2024.
- Secured targeted investment funding (TIF) of £62m for theatre, ITU and G&A bed expansion based on collaborative system working.
- Developing NEL Imaging Network in accordance with national strategy. NHSE have confirmed we have achieved 'developing' status based on our July 2023 maturity matrix review and have therefore met the national expectation for all networks to achieve developing status by December 2023
- Implemented Advice and Refer (A&R) across NEL, building on Barts Health advice & refer (A&R) programme and implementing A&R in select specialities in the Homerton and BHRUT systems.
- Successful evaluation of community ENT service in Tower Hamlets, Newham and Waltham Forest to secure recurrent funding alongside existing services in City and Hackney and Barking, Havering & Redbridge. Launched procurement for delivery of single ENT community service across NEL.
- Developed and launched 'Wait Well, Stay Well' website to help people to manage their own health and wellbeing by providing useful information and links to local and national resources primarily aimed at people waiting for hospital treatment
- Reprocured independent sector diagnostic provision across NEL. Preferred bidders have all been confirmed and implementation of new contract arrangements is underway.
- Leading work on the development of Women's Health Hubs building on existing model in City and Hackney. The pilot site in Tower Hamlets has been launched and a pilot is being developed by BHRUT and BHR places.
- The Tower Hamlets community dermatology service has commenced, supporting Royal London Hospital backlog clearance by taking direct referrals from the waiting list. A review of community dermatology across NEL by a multi-professional group, who have produced a preferred model of care to inform a new service specification for community dermatology which will standardise the service offer and reduce variation in equity of access
- Successful bid and implementation for an Ophthalmology single point of access in partnership with Moorfields which enables optometrists to make direct referrals to secondary care and reduce demand on primary care for onward referral.

Progress on long wait reductions

North East London Health & Care Partnership

Total waiting list

- The total waiting list across North East London has grown by 8.64% over the last year, from 194,957 in November 2022 to 211,806 in September 2023 The growth in waiting lists is across all 3 providers.

104 week wait position

- At week ending 05/11 there are 9 pathways >104ww (5 admitted; 4 non-admitted) at Barts Health; this compares to 396 pathways >104ww in April 2022 (232 pathways at Barts Health and 164 pathways >104ww at BHRUT).

78 week wait position

- At week ending 05/11 there are 330 pathways >78ww (177 admitted; 153 non-admitted) in NEL. 307 of these pathways are at Barts Health, and 23 pathways at BHRUT. This compares to 1,519 pathways in April 2022 (1,309 pathways at Barts Health, 208 pathways at BHRUT and 2 pathways >78ww at Homerton).

65 week wait position

- For week ending 05/11 there are a total of 3,029 pathways (1,018 admitted; 2,011 non-admitted) at NEL level (91% of which are at Barts Health).
- NHSE wrote to Integrated Care Systems in August 2023 regarding 'Protecting and Expanding Elective Capacity'. This set out the requirement for all systems to deliver the ambition to ensure all patients on a non-admitted waiting list at risk of waiting more than 65 weeks at the end of March, had a first outpatient appointment by 31 October 2023.
- There are currently 15,464 pathways at NEL level in the total 'breach' cohort (pathways that will breach >65ww in Mar-24). This cohort continues to reduce week on week and is down 32,218 (68%) pathways since end of July.
- As at week ending 05/11 there is a total of 4,892 pathways at NEL Level that have not yet had a first outpatient appointment (OPA).
- There are circa 2,350 pathways that have an OPA booked the majority of which will be seen prior to the end of December 2023. There are circa 2,500 pathways at NEL level that remain to be booked across Barts Health, BHRUT and Homerton.
- NHSE have indicated that Barts Health will be moved into Tier 1 for elective recovery. This reflects ongoing challenges in reducing long waits. Further information is to be provided about the implications of being in Tier 1. This is expected to involve weekly meetings with the NHSE national team and the potential for additional support from ECIST.

System working in planned care: collaboratives and placed based partnership

North East London Health & Care Partnership

- The planned care recovery and transformation programme is an integrated system programme with system wide engagement at its heart. Governance and delivery structures include partners from primary & community care, Place Based Partnership and the ICB.

- Each Place Based Partnership has identified Clinical Leads for Planned Care who work with the Planned Care Team to support transformation in outpatient, out of hospital and diagnostic services. In addition, the Planned Care Team has recently confirmed leads for each Place Based Partnership who will liaise and engage with PBP on planned care as well as support additional support on primary/secondary care interface work.

- Examples of joint working include:-
  - MSK – working with planned care leads at Place and the community collaborative. SRO for MSK programme is CEO of NELFT.
  - Women's Health – Women's Health Hub working group brings together clinical, operational and programme teams from primary care, place based partnership, secondary care and sexual health
  - Dermatology – clinical and operational working group bringing GPs, secondary care consultants, operational and programme teams to review dermatology provision and redesign community model of care.
  - Referral Optimisation – GP planned care leads from place based partnership are working with clinical and operational team in secondary care on
  - Diagnostic programme – GP diagnostic leads and Clinical Directors of place based partnerships and CDC referral pathways improving access to GP direct access and straight to test pathways,
  - Primary-Secondary Care Interface – joint work across the APC and Primary Care Collaborative on interface issues

Issues, Risks & Mitigations

North East London Health & Care Partnership

- Industrial action has had a significant impact on our ability to reduce waiting lists and increase activity in line with our operating plan commitments. Trajectories for achieving reducing 78- and 65-week waits have been revised in the 23/24 H2 submission to reflect impact of industrial action on activity during the first 6 months of the year. Further industrial action will have impact on our ability to deliver revised trajectories.
- There is a risk that national priorities to deliver urgent care and cancer recovery in the second half of 24/25 will impact on efforts to reduce long waits in elective care. In mitigation, all Trusts are focusing efforts on productivity, efficiency and transformation including targeting reduction in the non-admitted waiting list position during the winter months.
- There is a risk that the NHS financial challenge will result in a reduction in the use of outsourcing/insourcing to support diagnostic activity and lead to a further deterioration in performance against the DMO1 performance standard. Mitigation requires development and implementation of sustainable workforce model. This is across a range of modalities including imaging, endoscopy and audiology.
- The requirements of capital expenditure limits poses a risk to the phasing and delivery of CDC programme, with all 3 sites expecting to phase spending differently between financial years composed to original plan. This is an issue for the CDC programme across the country and NHSE are working with systems to agree mitigation plans to manage slippage across financial years.
- There is a risk that the NHS financial challenge prevents opportunities for testing new models of care that require short term investment and have the potential for creating sustainable improvements in equity of access. This is being mitigating by exploring alternative ways of working to test new ways of working within existing resources across partner organisation.
- There is a risk that planned increasing in surgical capacity funded through the Targeted Investment Fund will not be fully realised due to unforeseen additional capital costs. Opportunities to close the gap during 24/25 capital planning are being explored as mitigation.

North East London
Integrated Care Board

NHS North East London ICB board

29 November 2023

Title of report	Supporting Equity and Sustainability in north east London – briefing pack for NHS England meeting, outcome and next steps
Author	Hilary Ross, Director of Strategy, System Development and Innovation
Presented by	Zina Etheridge, Chief Executive Officer
Contact for further information	hilary.ross1@nhs.net
Executive summary	One of the ICB's roles is to plan to meet the health needs of the population. In response to the policy of successive national and regional administrations, north east London is the fastest growing health economy in the country. Alongside significant overall growth, the population in our places is also changing with an aging population in some traditionally younger places whilst some of our outer boroughs have the fastest growing child population in the country. The speed and volume of growth means that our funding is already challenged across revenue and capital. This pack sets out the key parameters of that growth and explains why funding mechanisms don't keep pace. It sets out the case for funding to meet the needs of our growing population, and describes the importance of investing in population health, innovation and prevention so that our health economy is sustainable and supports our people to have healthy lives. We are working with NHS England (NHSE) to further develop our collective understanding of the programme of work required to develop robust future plans that can be invested in. We will continue to make the case for north east London to be a test bed for innovation – following our recent success in gaining investment for a health navigator programme. We are working with NHSE to make the case for further capital investment.
Action / recommendation	The Board is invited to consider: • How to further make the case for funding to meet the needs of our fast growing population; • To consider how population health approaches can help deliver a sustainable health economy which supports healthy lives within the context of rapid growth; • To consider how we can, within very tight current financial constraints, continue to focus on prevention as part of our overall response to preventing that

	growing population increasing in ill health to the same proportion as growth.
Previous reporting	Population Health and Integration Committee on 25 October 2023.
Next steps/ onward reporting	Dependent on the Board's discussion, it is anticipated that the population health and integration committee will return to the themes in the pack as part of its ongoing work and to receive updates on the programme of work described above. Elected members have already asked for a shorter version of the pack to support their discussions with stakeholders, in the form of a 'manifesto for north east London'.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
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 • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	This pack aimed to support discussion with national colleagues on greater support for north east London (NEL) to increase equity for our population. Greater understanding of the unique challenges being faced in NEL will be key to increasing support/ resource from NHSE. National support will aid local people by helping NEL manage the expected future service demands, for example, strengthening and growing services in areas such as primary and community care in order to improve preventative pathways. This will in turn support sustainability of services in the face of our growing population whilst also providing an opportunity to embed health inequality approaches.
Impact on finance, performance and quality	Securing further support/ resources against our revenue and capital requests will contribute to improving our performance, quality and finance challenges by helping to mitigate against our unfunded increased population growth. NEL would also have the opportunity to receive priority consideration for national innovation programmes concerning areas such as prevention and equity, further supporting new ways of working and ensuring quality and performance are improved.
Risks	The risks in this paper relate to the impact of future growth on services without adequate planning and resource. There are no significant risks associated with the production of a narrative.

NHS
North East London

Supporting equity and sustainability in North East London

Summary of our ask

Key areas of support

North East London has a **large, vibrant and highly diverse population** spanning eight local authorities. Our **rapidly growing** population experiences some of the worst **poverty and deprivation** in the country, **poorer outcomes** across many indicators and there is evidence of **significant unmet need**.

There is **collective agreement and support** across the integrated care partnership in north east London for our **new and ambitious strategy** that puts **innovation**, **co-production, prevention, personalisation, and equity** at the heart of how we work. Building on our successful track record of delivering transformation, our expanding architecture for innovation and research, as well as the new opportunities afforded to us through the ICS, we believe we can make a significant difference to **population health and equity** while also creating a more **sustainable health and care economy** in north east London.

However, systemic barriers are currently impeding our progress. Our ICS is **undercapitalised** which means it is impossible to invest in the technology and digital developments that are needed to move away from more traditional and resource intensive models of care. We lack the investment in **physical infrastructure** that is needed for population growth of the scale we expect to experience in north east London, and our **revenue** is inadequate for meeting our population need.

We are therefore seeking national support in the following key areas -

I. Additional non-recurrent revenue investment in a 10 year programme that seeks to strengthen, transform and grow capacity in primary and community services to help mitigate the unfunded increased population over and above that assumed in the funding formula

II. National funding of a team to work through the detail of the above, with a view to jointly agreeing a methodology and funding

III. Further investment in NEL capital to address our current baseline deficit, historic shortfalls in funding and the new capacity required to meet the demands of unprecedented population growth

IV. Prioritisation of NEL ICS by national teams as a test-bed of choice for innovation, particularly digital (as has recently been agreed for the Health Navigator urgent care innovation) supporting our increased focus on prevention and equity

V. Unlocking of the existing scheme at Whipps cross to secure the benefits for our current population and reduce the impact of the risks being held by the ICS

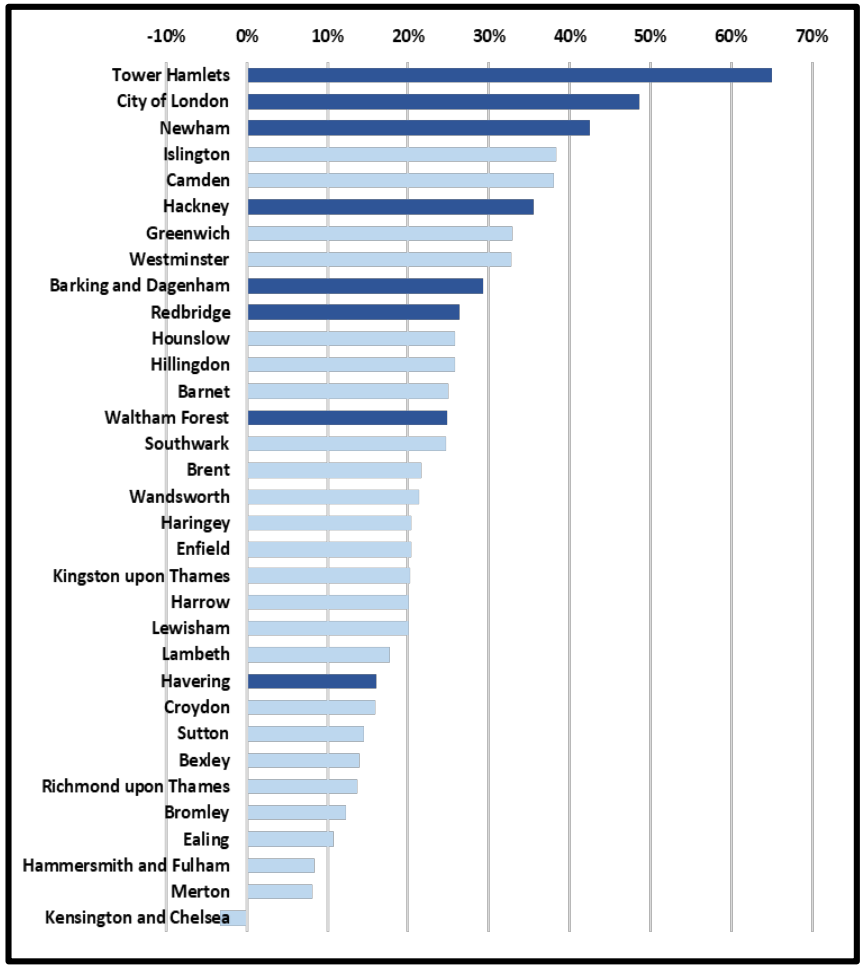
Context: our diverse and deprived population is growing (and ageing) rapidly

The scale of population growth in NEL has put significant pressure on health and care services over the last 20 years

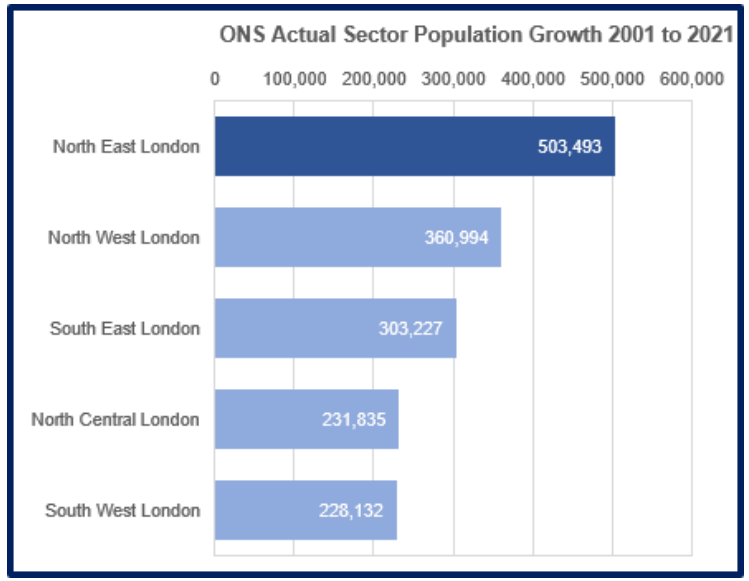
NEL has had the fastest growing population in the country over the last 20 years

- The London region has seen the largest population growth in the country over the last 20 years, growing twice as fast as the rest of the country.
- NEL continues to be the fastest growing ICS in London, growing twice as fast as the other ICS's.
- NEL has the three fastest growing boroughs in England, and six of the 10 fastest growing boroughs in London.

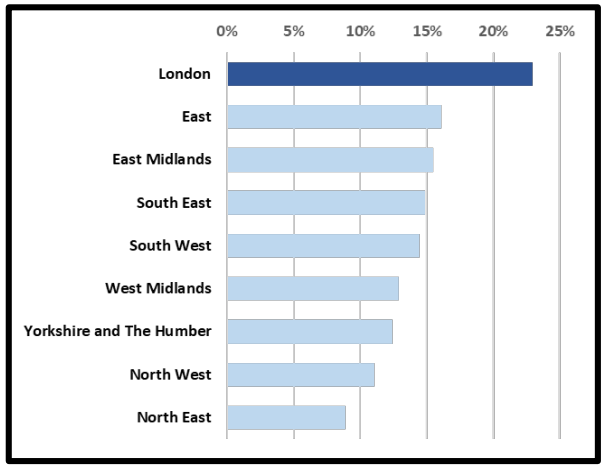
ONS London Neighbourhood population growth 2001-2021



ONS Sector population growth 2001-2021



ONS Regional population growth 2001-2021



Rapid population growth in NEL is set to continue and will exceed national projections

The rapid population growth for NEL is forecast to continue driven by population demographics and London's housing plans

The ONS forecast on which NHS allocations are based indicates continued high growth in NEL, however, the Greater London Authority (GLA) population projections which also take account of local housing plans point to growth being significantly higher than the ONS forecast. This is true even of the GLA's most conservative planning scenario. The implications of this are a significant lag in funding for NEL to match the rate of growth.

The ONS forecasts a growth in NEL population of **206,226** between 2021 and 2041.

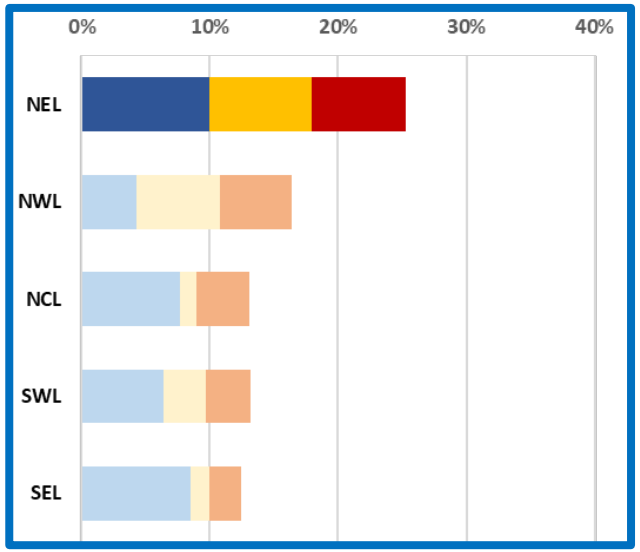
The GLA has produced planning scenarios indicating significantly increased growth in NEL:

Past Delivery Scenario:
Housing growth at historic delivery rates
Projecting a population increase of **308,576** by 2041

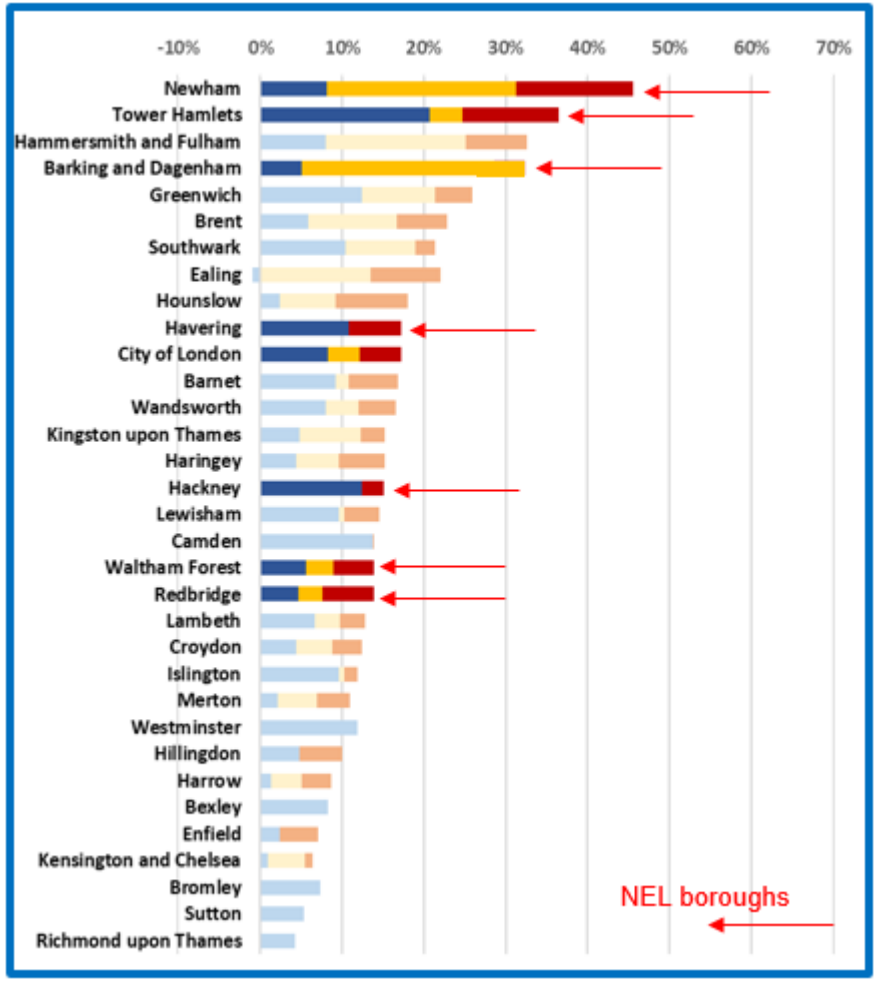
Identified Capacity Scenario:
Housing growth in line with identified development sites
Projecting a population increase of **331,432** by 2041

Housing Targets Scenario:
Housing growth in line with government housing targets
Projecting a population increase of **379,757** by 2041

GLA housing-led population projections by ICS 2021-2041



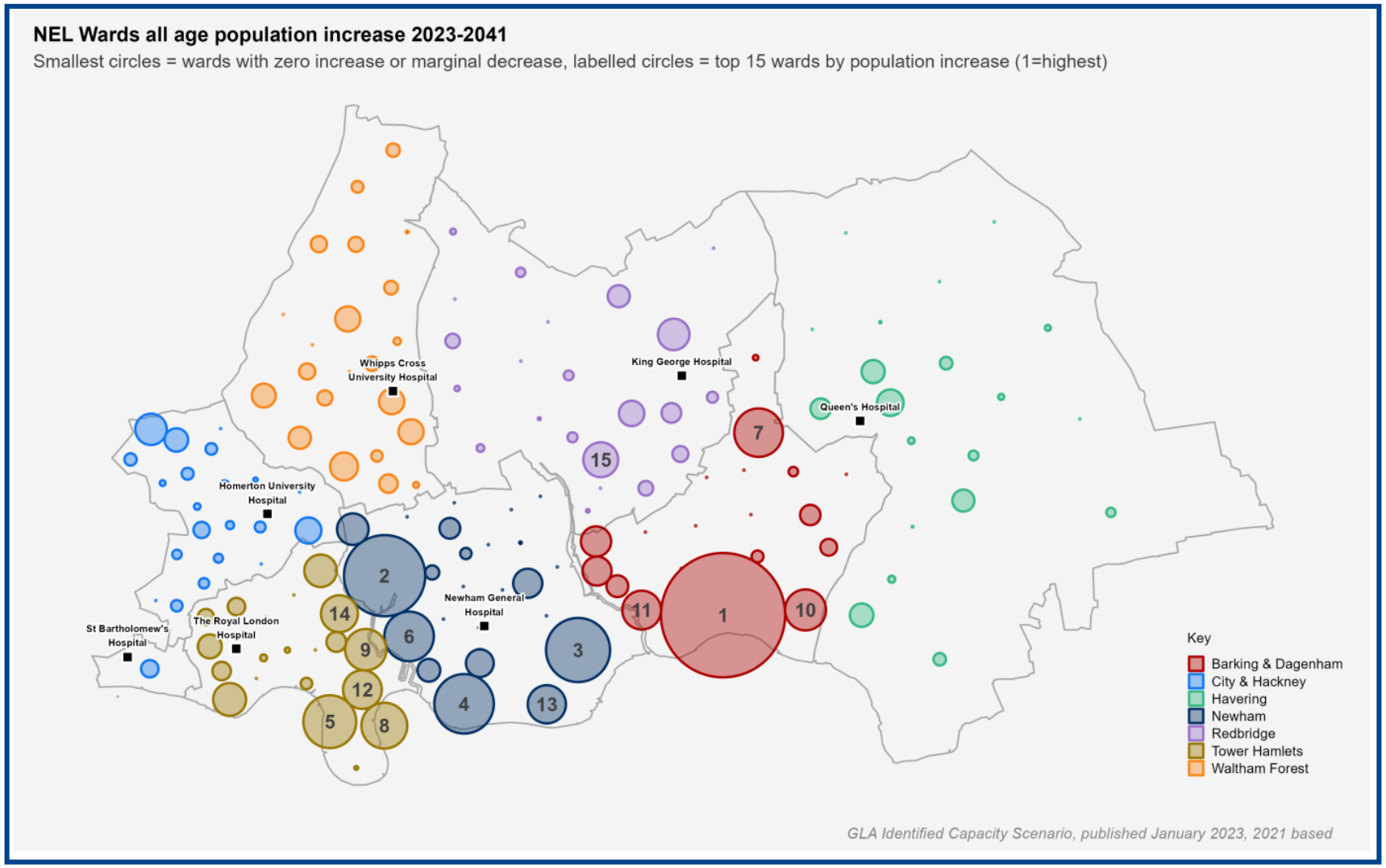
GLA housing-led population projections by LA 2021-2041



Sources: ONS sub-national population projection by local authority, 2018-based ; GLA housing-led population projections, 2020-based (graphs) and 2021-based (quoted figures)

Growth is unevenly distributed across NEL and particularly significant in some of our most deprived and currently underserved places

NEL service provision will need to adapt to new demands as NEL's Population Growth is unevenly dispersed .



Our **rapidly growing** population experiences some of the worst **poverty and deprivation** in the country, with **poorer outcomes** across many indicators and evidence of **significant unmet need** (Annex 1, slides 16-19).

Furthermore, our **hotspots of population growth** in NEL are focused in some of the most deprived parts of our geography including LB Barking & Dagenham where over half of the current population (54%) live in the most deprived quintile nationally and LB Newham where a quarter of the population live in the most deprived areas nationally (24%).

The place with highest projected growth in north east London (LB Barking & Dagenham) currently **lacks the essential infrastructure for health and care**. There is insufficient primary care capacity for existing growth in Barking and Dagenham and no acute provision whatsoever within the borough.

Demographic changes within our growing population will require greater investment in new infrastructure and services

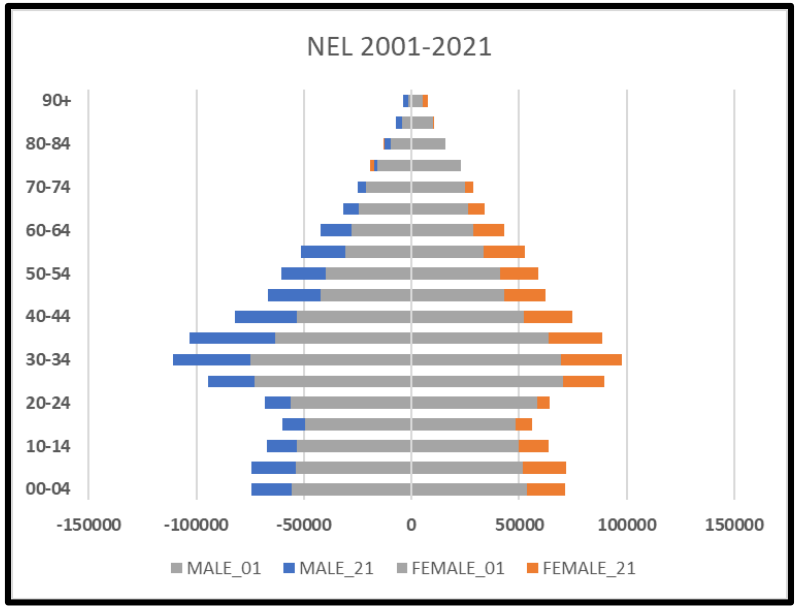
Historically our population growth has been mostly across children and adults whereas in future NEL will see growth predominantly in adults and older people. This will lead to significantly increased pressure on older peoples care services, frailty services, primary care services, and increasing pressure on emergency and urgent care services, adult care services, and adult mental health services.

Increased investment in developing services and infrastructure for a changing population will be needed particularly in those places (e.g. LB Tower Hamlets and LB Hackney) where historically there has been a very young population and in future we will see a significant increase in over 60s.

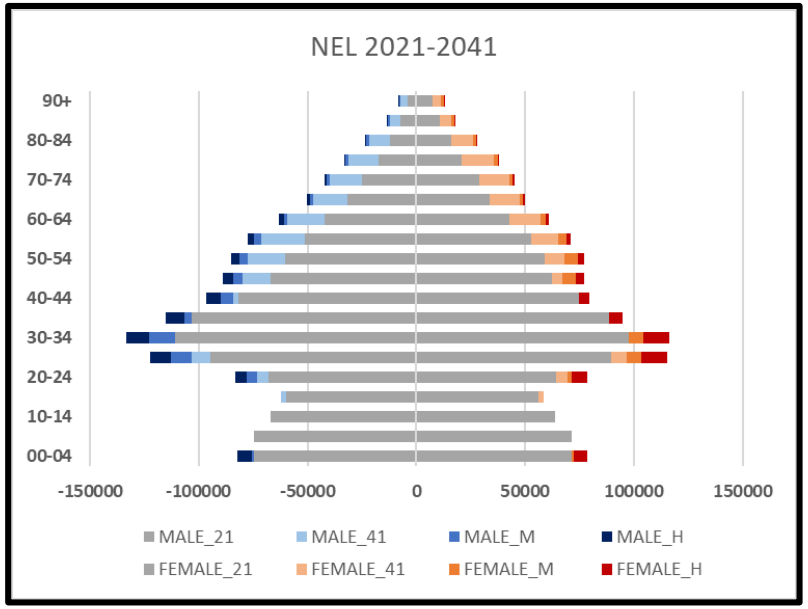
While an ageing population is an overall trend in what have been historically young boroughs, LB Barking & Dagenham will see the opposite trend and as such will need to increase investment in services for children and young people.

Trends in growth across NEL have typically been in young people and adults – whereas future growth will be across adults and older people contributing to a forecast 72% increase in outpatient and inpatient activity over the next 19 years

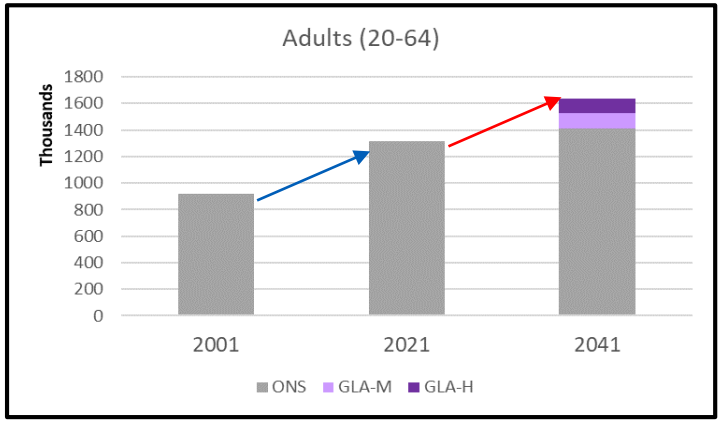
Historic Demographic Growth

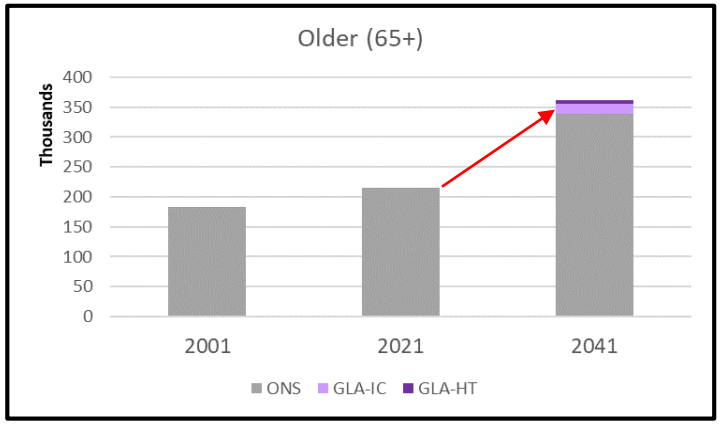


Future Demographic Growth



Growth by cohort





Addressing our challenges as an ICS in NEL

NEL ICS has aligned around a new integrated care strategy

Our integrated care partnership's ambition is to –

"Work with and for all the people of north east London to create meaningful improvements in health, wellbeing and equity."

Improving quality & outcomes	*Deepening collaboration*	*Creating value*	*Securing greater equity*

Six *crosscutting themes* underpinning our new ICS approach

- Tackling *Health Inequalities*
- Greater focus on *Prevention*
- Holistic and *Personalised* Care
- *Co-production* with local people
- Creating a *High Trust Environment* that supports integration and collaboration
- Operating as a *Learning System* driven by improvement, research and innovation

Four *system priorities* for improving quality and outcomes, and tackling health inequalities

- *Babies, Children & Young People*
- *Long Term Conditions*
- *Mental Health*
- *Local employment and workforce*

Securing the foundations of our system

Improving our *physical* and *digital infrastructure*
Maximising *value* through collective financial stewardship, investing in *prevention* and *innovation*, and improving *sustainability*
Embedding *equity*

We are becoming a thriving testbed for research and innovation

In addition to the many examples of successful service developments (e.g. Barts Heart Centre) and wider transformation across all parts of the system in NEL (Annex 2, slides 20-21), we are actively growing our research and innovation architecture to ensure we can deliver better outcomes for our growing population aswell as enabling greater value for money and sustainability as a system.

Bart's Health Life Sciences will be a major local and national asset bringing key infrastructure for researchers, scientists and clinicians working alongside businesses and entrepreneurs with the aim of becoming world-leading in prevention, prediction and precision (see box, right).

NEL already hosts a wealth of research and innovation assets:

- The **Clinical Effectiveness Group** at Queen Mary University London established 30 years ago uses data to support primary care improvement in population health (NEL ICS has just been ranked first nationally in CVD prevention and outcomes).
- **Care City** is an innovation centre for healthy ageing and regeneration with a mission for happier and healthier older age for east Londoners, achieved via research, innovation and workforce development.
- **EQUIP** (Enabling Quality Improvement in Practice) works across east London primary care supporting staff engagement and improvement approaches.
- We are also an active member of the North Thames Clinical Research Network, North Thames Applied Research Collaborative and UCLPartners.

Bart's Life Science Vision:

- Working with a **highly diverse population**, we will make a significant impact on health inequalities
- Extending and developing our **clinical research capacity**
- Using **big data and AI** to develop analytic and predictive tools
- **Precision medicine** for targeted interventions
- Creating **thousands of jobs** and **£Bs economic impact**
- Tackling economic determinants of health through **skills and employment opportunities**

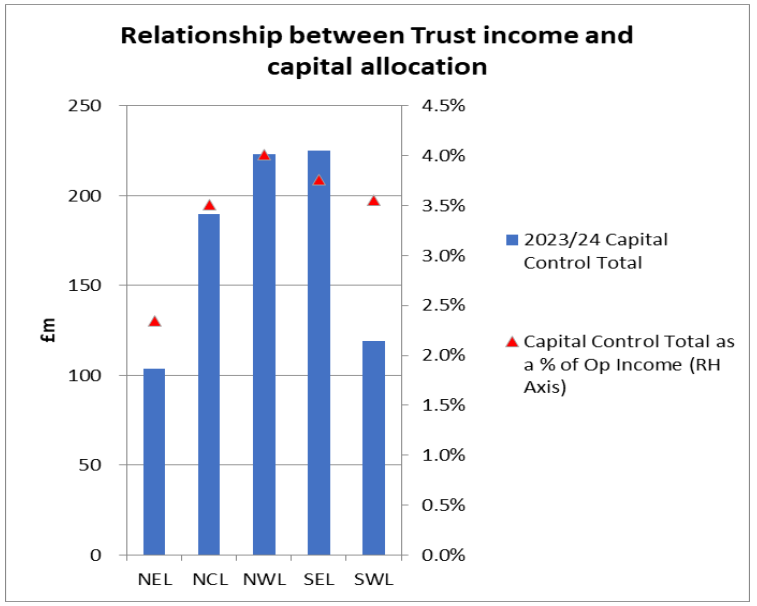
Innovation is at the heart of new developments in NEL – we are launching a **Research Centre for Healthy Ageing** at Whipps Cross Hospital. The centre led by Barts Health and QMUL will create a collaborative network of clinicians, researches, educators, policymakers working with local communities researching how to transform how services work for older people, supporting them to live well and independently. Other developments we are scoping include the opportunities for primary care from the life sciences developments at Whitechapel, lifesciences developments at Canary Wharf, and a partnership with the national Dementia Research Institute to support our centre of excellence for older people at East Ham.

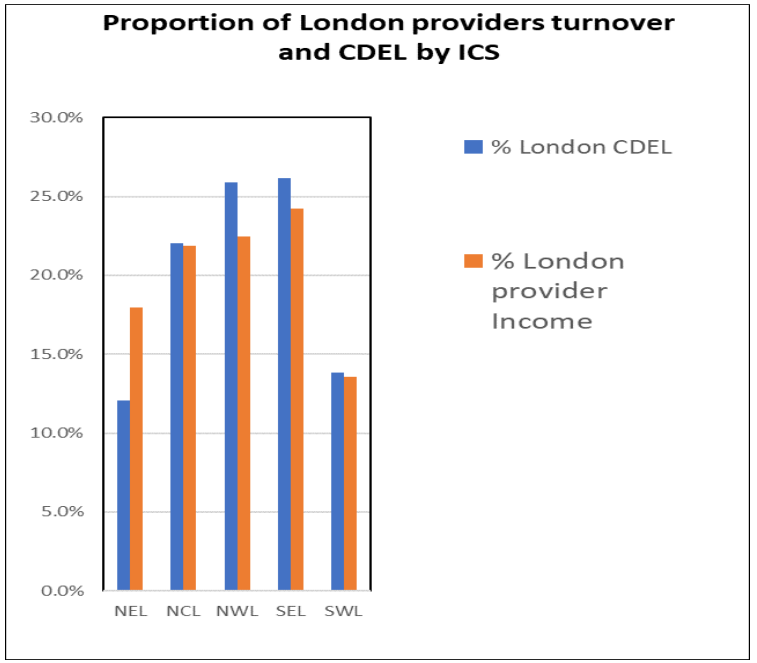
Over the last year, NEL ICB has developed a research strategy to support our learning system ethos. We have developed a portal that helps to connect researchers with local clinicians and the ICB, and we have been awarded two national grants for increasing engagement of our diverse local communities in research. We are undertaking a range of evaluation activities across our programmes to ensure we understand the impact of our investment including in our pioneering work on personalisation and social prescribing. Our Acute Provider Collaborative has also developed plans for delivering a step change in clinical research. Current research projects include closer integration with community services on social prescribing for long-term or medically unexplained conditions.

Systemic challenges that are holding us back

Significant undercapitalisation

- According to NHSE, NEL has the lowest CDEL per population in England. NEL continues to receive the lowest capital allocation in London : in 2023/24 NEL £87.2m, SEL (highest) £225.2m.
- A significant contributory factor to the low capital allocation is the treatment of PFI in the current methodology for deriving capital allocations. The higher the value of PFI assets the greater the negative impact on the non PFI asset capital allocation. This is particularly significant for NEL which has over half of the total London PFI assets (by value).
- There is no unambiguous measure of the relative capital need of an ICS, but, it is possible to use the allocation as a proportion of provider income, as a proxy for total work done and need for capital to support this work. This metric also accounts for local variations such as specialist work and inflows from other systems. This can be seen the charts, NEL with both the lowest CDEL % of provider income and the only London ICS with its allocation % of London lower than its % of London provider income.
- On this basis, the difference: 2.3% for NEL against 3.5% - 4% rest of London. i.e. the next lowest ICS in London has proportionally **50%** higher capital allocation than NEL. NEL is also one of the lowest resourced ICS in the country, using this metric.
- Reviewing the NEL capital position using these benchmarks would suggest an increase in allocation of c.£80m would be appropriate and equitable.
- Whilst recognising the benefits of the PFI estate, the treatment of PFI in the allocation formula results in a significant reduction to the non PFI capital allocation available to the sector of c.£37m/year.





Impact of the disadvantaged capital position in NEL

The impacts and current challenges faced by NEL ICS with our current capital position.

Three key capital challenges facing NEL:

1. **Our allocation is absorbed by the maintenance of our existing basic infrastructure and equipment -**

   - **Backlog / preventative maintenance:** We are currently prioritising essential backlog maintenance to ensure service continuity covering both preventative maintenance and improvement of our assets (90% of our allocation assigned in 23/24). However, this is still insufficient for addressing the backlog which increases each year and is starting to impinge on our ability to keep sites and services operational. Delays to routine replacement of equipment lead to equipment failures we lack resources to address in a timely way.

   - **Climate change and adaption:** Limited funds are available for addressing climate resilience. Scope to incorporate into backlog work is limited due to the need to address basic repairs / maintenance as a priority.

2. **We lack investment for new technologies and digital to increase our productivity -**

   - **New technology:** Investment in new technology (new technology and 'new' for NEL) is inhibited by lack of funds and the need to prioritise essential backlog as above. The lack of investment impacts innovation in service delivery and our ability to increase productivity and accelerate improvement.

   - **Productivity:** concentrating on backlog for safety reasons and keeping services open means little or no investment in equipment that would improve productivity and reduce revenue costs. There are numerous examples across community (delayed IT investments impacting efficiency programmes), infrastructure (can no longer support modern energy requirements for additional diagnostic tools), capacity (sub-optimal use of estate leading to excess overhead) and elevated agency usage (impact on staff recruitment and retention from poor quality environment).

3. **We have insufficient infrastructure to support our growing population -**

   - **Additional capacity:** Capital is required to create additional capacity in new and existing premises to support modern clinical models of care in areas of significant population growth. For example: A&E department at Newham Hospital was built to accommodate 200 contacts a day and now sees in excess of 500 as a result of demographic changes and existing population growth; there is insufficient primary care capacity in Barking town centre to accommodate existing growth.

   - **Delays to existing schemes:** We are awaiting confirmation from the national programme for the Whipps Cross redevelopment which is a key development for our existing population. The ICS is currently holding the risks from significant delays.

Revenue implications of rapid growth in NEL

The National funding allocation formula does not account for NEL's house building increase. The Mayor's London Plan also indicates significant NEL areas as 'London Opportunity Areas'.

The rapid growth and demographic changes as described above, also create two key revenue challenges for the ICS in NEL:

1. Financial lag –

As described above, the national funding allocation formula uses ONS population projections which understate population pressures, particularly those related to high levels of housing development and changes in demographics, as is the case in NEL. The London specific GLA projections give a more accurate picture as they account for these factors.

A funding formula that does not take these factors into account takes longer to recognise the rising population and results in financial pressures for the system. This situation perpetuates until the population stabilises (c. 20 years on our calculations) meaning that there are significant delays to establishing the additional services needed to meet the needs of the growing population.

This table illustrates the financial impact of the lower ONS population projection with an estimated unfunded 0.8% difference in 2023/24 which equates to a value of c.£32m. Similar calculation for 24/25 indicates c.£59m shortfall, or c.£91m over the current 2 year allocation period.

	ONS In year growth	GLA in year Growth	Difference	Value of difference 2023/24	Value of difference 2024/25
	%	%	%	£m	£m
Impact difference ONS vs GLA	0.6%	1.4%	0.8%	32	59

2: Accelerated demographic change –

As the age profile of our population changes, the services that are currently in place no longer meet the needs of our rapidly expanding populations. If growth was slower this could be dealt with through incremental changes to the existing services.

A different approach is needed to support us with systemic challenges

The primary finance challenges faced by NEL

We are seeking national support to overcome the following challenges which are beyond our control -

1. **Additional non-recurrent revenue investment in a 10 year programme** that seeks to strengthen, transform and grow capacity in primary and community services to help mitigate the unfunded increased population over and above that assumed in the funding formula towards a more sustainable foundation for our system. Our partnership has a successful track record of transformation where there has been appropriate investment. We want to accelerate adoption of innovation to move more activity out of the acute sector, investing in primary care, community services and prevention. To do this we need additional non-recurrent funding to pump-prime and double run services while evaluating robustly so we have the evidence to support rapid scaling.

2. **Nationally funded programme team** to work through the detail of the above with a view to jointly agreeing a methodology and funding.

3. **Significant non recurrent support to resolve the backlog caused by historic undercapitalisation** built up over the last 5-10 years. Without this NEL will never get to a safe and sustainable position with regard to our clinical estate (e.g. fire works, low numbers of beds), productivity (e.g. lack of additional power supply preventing modernisation of sites), clinical equipment (e.g. low numbers of diagnostic tools), IT (e.g. security, agile community services) and digital systems (e.g. BHRUT EPR). This capital resource problem spills into poor revenue performance and practice and needs to be in place to help resolve these underlying issues.

4. **Additional non recurrent capital investment in new resources, renovations and assets for our growing population** (not currently recognised in the capital allocation) stretching over the next 10 -15 years are needed, otherwise NEL cannot absorb a 20%+ increase in population with an asset base that is already overstretched. Non recurrent funds are necessary to cover the cost of the systemic transformation required by fundamental demographic change that will take place through the much needed housing developments taking place in NEL.

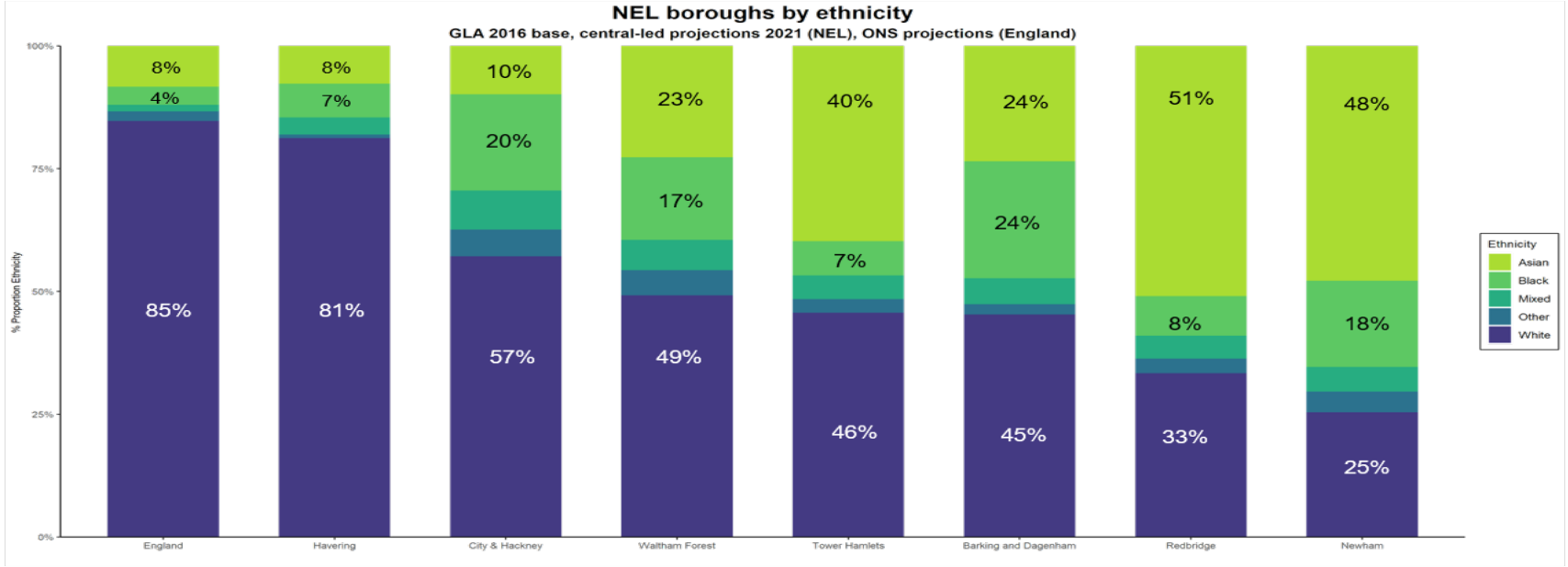
5. **Recurrent amendment to the allocation methodology to address ongoing capital underfunding** and ensure NEL receives a fair and commensurate level of funding in future years.

Annex 1 - our NEL population

NEL ICS has one of the most diverse and deprived populations nationally

Deprivation:

- Barking and Dagenham is ranked 22nd and Hackney 23rd most deprived out of 312 local authority areas in England. Newham is ranked 43rd and Tower Hamlets 50th
- Across ALL of NEL, 24% (approximately 489,000 people) live in areas ranked in the most deprived 20% in England
- In Barking and Dagenham, over half – 54% (116,000 people) live in an area ranked among the most deprived quintile.
- In City and Hackney, 40% of the population (117,000 people), Tower Hamlets 29% (95,000 people), and in Newham 24% (87,000 people) live in LSOAs ranked in the most deprived quintile



Ethnicity:

- More than half (53%) of NEL's population is of Black, Asian or mixed ethnicity compared with 11% across England overall
- The places of North East London vary greatly in their diversity: Newham is the most ethnically diverse place in NEL. In contrast, Havering sits at the other end of the spectrum in NEL with the vast majority (81%) of its population of White ethnicity compared with 8% identifying as Asian ethnicity. However, all are more ethnically diverse than the England average.
- All NEL places except Havering and City and Hackney (combined) have predominately non-white populations.
- Newham is one of the most diverse boroughs in England. Those of white ethnic groups in Newham account for 25% of the population and those of Asian ethnic groups make up nearly half (48%) of the population. This compares to 85% and 8% for England.
- Redbridge is the second most diverse place in NEL, with 67% of its population being of Black, Asian, Mixed or Other ethnicity.

Outcomes are worse for our current population across many key national indicators

Best start in life:

- All NEL places except Hackney and Havering have a higher proportion of term babies born with a low birth weight than the England average (2.86%).
- The stillbirth rate in Newham (5.5 per 1,000), Tower Hamlets (5.5), and Barking and Dagenham (6.2) is significantly higher than the England average (4.0).
- Rates of A&E attendances by young children in Newham (821 per 1,000) and Waltham Forest (728 per 1,000) are significantly higher than the England average (670 per 1,000).
- In Waltham Forest (14%), Barking and Dagenham (14.8%), Hackney (27.7%) and Tower Hamlets (33.6%) the proportion of children claiming free school meals is higher than the England (13.5%) average. The rate in Hackney and Tower Hamlets is more than double the England rate. This indicator is considered a good proxy for low parental income.
- All NEL places, except Waltham Forest, have a rate of children in need that is higher than the England average (635 per 10,000)
- Havering is an outlier having higher rates (117 per 100,000) of hospital admissions of 15-24 year olds due to substance misuse than the England (81 per 100,000) average. Havering is the ONLY place in London where the rates are higher than the England average.

Working Age Adults - Major Health Conditions:

- Higher under 75 mortality – all cardiovascular diseases: Hackney, Tower Hamlets, Newham, Waltham Forest and Barking and Dagenham have a mortality rate from all cardiovascular diseases higher than the England average of 70 per 100,000 population.
- Higher prevalence diabetes: In Havering (7.64%), Barking and Dagenham (8.6%), Newham (8.6%) and Redbridge (9%) the diagnosed prevalence of diabetes is higher than the England (7.1%) average. Rates are increasing in all places except Newham.
- Higher under 75 mortality from cancer: Barking and Dagenham (115.5 per 100,000) has an under 75 mortality rate for cancer that is higher than the England (100 per 100,000) average.
- Tackling chronic respiratory disease is one of the 5 clinical priorities in the NHS Core 20 plus 5. Under 75 mortality rate from respiratory disease is worse than the England average in Tower Hamlets (44 per 100,000) and Barking and Dagenham (60 per 100,000).

Working Age Adults - Mental Health:

- Estimated prevalence of common mental disorders: City and Hackney (24%), Newham (24%), Tower Hamlets (23%), Waltham Forest (23%), and Barking and Dagenham (22%) have an estimated prevalence of common mental disorder higher than the England (17%) average.
- High prevalence severe mental illness: City and Hackney (1.42%), Tower Hamlets (1.32%), Waltham Forest (1.17%) and Newham (1.12%) have a higher prevalence of severe mental illness than England (0.95%). Ensuring annual health checks for 60% of those with severe mental illness is one of the 5 clinical targets included in the NHS Core20 Plus 5 drive to reduce health inequalities.
- High inpatient stays in secondary mental health services: City and Hackney (505 per 100,000), Newham (401 per 100,000), Tower Hamlets (304 per 100,000) and Waltham Forest (282 per 100,000) have a rate of inpatient stays higher than the England (243 per 100,000) average.
- High under 75 mortality for adults with severe mental illness: Tower Hamlets (147 per 100,000), Barking and Dagenham (143 per 100,000), Hackney (119 per 100,000) and Newham (140 per 100,000) have a rate of under 75 mortality for adults with severe mental illness higher than the England (103.6 per 100k) average.

There is evidence of significant unmet need within our current population

We need a greater focus on prevention, addressing unmet need and tackling health inequalities

Child Obesity

Nearly 10% of year 6 children in Barking and Dagenham are severely obese. Nearly a third of children are obese (the highest prevalence rate in London).

NEL also has a higher proportion of adults who are physically inactive compared to London and England.

Mental Health

It is estimated that nearly a quarter of adults in NEL suffer with depression or anxiety, yet QOF diagnosed prevalence is around 9%. Whilst the number of MH related attendances has decreased in 22/23, the number of A&E attendances with MH presentation waiting over 12 hours shows an increasing trend increasing pressure on UEC services.

Tobacco

1 in 20 pregnant women smoke at time of delivery. Smoking prevalence as identified by the GP survey is higher than the England average in most NEL places. In the same survey NEL has the lowest quit smoking levels in England.

Premature CVD mortality

In NEL there is a very clear association between premature mortality from CVD and levels of deprivation. The most deprived areas have more than twice the rate of premature deaths compared to the least deprived areas. 2021/22 figures showed for every 1 unit increase in deprivation, the premature mortality rate increases by approximately 11 deaths per 100,000 population.

Vulnerable housing

NEL has high numbers of vulnerably housed and homeless people, including refugee and asylum seekers, compared to both London and England. At the end of September 2022 11,741 households in NEL were in council arranged temporary accommodation. This is a rate of 23 households per thousand compared to 16 per thousand in London and 4 per thousand in England as a whole.

Homelessness

Shelter estimate in 2022 there were 42,399 homeless individuals in NEL. Inc. those in temp accommodation, hostels, rough sleeping and in social services accommodation: 1 in 47 people, compared to 1 in 208 people across England and 1 in 58 in London. People experiencing homeless have worse health outcomes & face extremely elevated disease and mortality risks which are eight to twelve times higher than the general population.

Childhood Poverty

5 NEL boroughs have highest proportion of children living low income families in London. In 2020/21 98,332 of NEL young people equate to 32% of the London living in low-income families. Since the 2014 the proportion of children living in low income families is increasing faster than the England average.

Childhood Vaccinations

The NEL average rate of uptake for ALL infant and early years vaccinations are lower than both the London and the England rates

There are particular challenges in some communities/parts within Hackney, Redbridge, Newham and B&D where rates are very low with some small areas where coverage is less than 20% of the eligible population.

There is clear indication of unmet need across our communities in NEL

For many conditions there are low recorded prevalence rates, while at the same time, most NEL places have a higher Standardised Mortality Ratio for those under 75 (SMR<75) – a measure of premature deaths in a population – compared to the England average. Whilst some of this may be due to the age profile of our population, there may be significant unmet health and care need in our communities that is not being identified or effectively met by our current service offers.

Annex 2 – some examples of successful transformation in NEL

A track record of successful transformation

Examples of transformation we have driven within existing resources

Cardiovascular Disease:

NEL ICS is the top ranking 1st in England in key Cardiovascular prevention and disease outcomes including management of hypertension, atrial fibrillation, chronic kidney disease, heart disease and stroke, and people at high CVD risk.

Long Term Conditions:

The Non-Invasive Ventilation (NIV) Service, which went live in April 22, has been put in place for the management of chronic hypercapnic respiratory failure (CHRF). Previously the service was only available through Tertiary institutions however will now be delivered locally by BHRUT to patients at home.

Children's LTCs:

City and Hackney practices have led the development of Long term conditions (LTC) integrated management with 80% of eligible children receiving an annual review with personalised care plan, 65% of children with diabetes, sickle cell and epilepsy receiving an annual care contact from their practice.

Elective Services:

We have an established planned care recovery and transformation programme. An integrated system programme initially set up in October 2021 to recover the elective backlog and improve equity of access for our population, led by the Acute Provider Collaborative.

ELFT Community Health Services:

Pharmacy input into district nursing teams (HSJ Award category finalist) improved outcomes for both medicines management and medicines optimisation. Delivered via system innovation and new ways of working

First Contact Physiotherapy:

An integrated PCN wide physiotherapy clinic that required the set-up of a cross organisational booking system. Resulting in beneficial patient experience.

Young Peoples Outpatient Services:

Tower Hamlets has established a young people's GP clinic called 'Health Spot' aligned with youth provision rights in order to provide a trusted approachable environment where young people are able to see a doctor, specialist nurse or mental health worker. Supporting them with integrated holistic healthcare, health literacy and empowerment.

Transforming Outpatient Services:

Our GPs can now receive advice directly from a number of specialist consultants, reducing hospital attendance and giving speedy care. In 2022/23 we achieved against the 16% national ask for advice and guidance requests across 2022/23, and for approximately 29% of all outpatient appointments in January.

North East London
Integrated Care Board

NHS North East London ICB board

29 November 2023

Title of report	Deep dive: cancer
Author	Femi Odewale, Managing Director, North East London Cancer Alliance
Presented by	Femi Odewale, Managing Director, North East London Cancer Alliance
Contact for further information	femi.odewale@nhs.net
Executive summary	This paper is in response to the request for a deep dive into the entire cancer pathway in north east London, covering: • Prevention, awareness, and screening • Diagnosis • Treatment • Support for people living with cancer • End of life care It highlights some recent achievements of the North East London Cancer Alliance across the whole cancer pathway, including our work with Public Health, local authorities, and local voluntary and charity partners.
Action / recommendation	Note
Previous reporting	This paper has also been shared with the ICS Executive Committee meeting on 9 November 2023.
Next steps/ onward reporting	N/A
Conflicts of interest	N/A
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	We are committed to improving cancer outcomes and reducing inequalities for local people. Work across our three core programmes is focussed on reducing the health inequalities gap and we have recently presented this work at the National Cancer Alliances 'share and learn' session.
Impact on finance, performance and quality	There are no additional resource implications, revenue costs or capital costs arising from this report. The team is currently working on the strategy for April 2024 to March 2025.
Risks	Risks to the delivery of the work of the cancer alliance are impacts of industrial action, political changes and challenges around the recruitment and retention of cancer staff.

1.0 Introduction and context

1.1 This paper provides information on the work underway to support the residents of north east London through the entire cancer pathway, covering:

- Prevention, awareness and screening to support early diagnosis
- Diagnosis
- Treatment
- Support for people living with cancer
- End of life care

1.2 It highlights some key recent achievements for the attention of the Board. As well as ensuring the North East London Cancer Alliance delivers its plan for 2023-2024, this work also enables the ICB to achieve its objectives, as set out in the interim strategy, across the ICB's six cross-cutting themes:

- Tackling Health Inequalities
- Greater focus on Prevention
- Holistic and Personalised Care
- Co-production with local people
- Creating a High Trust Environment that supports integration and collaboration
- Operating as a Learning System driven by research and innovation

1.3 More information about the cancer alliance, including the benefits of the cancer alliance, roles and responsibilities and the way we work with partners across north east London, is in appendix A.

2.0 Prevention, awareness, and screening to support early diagnosis

2.1 Prevention, awareness and screening aims to find any cancer at an earlier stage, when it is easier to treat, and also to find ways to pick up cancers before they develop, for example by increasing the number of people who attend screening programmes (see section 2.6 below).

2.2 Another priority for north east London is to reduce the number of people coming forward at a late stage to get checked for a cancer diagnosis (for example, going straight to the emergency department rather than their GP). The aim is to **reduce the number of people being seen with late-stage cancer** (stages 3 and 4, rather than stages 1 and 2) where symptoms are more advanced, and it is more difficult to treat.

2.3 Work to support these priorities includes:

- ***Working at a borough level to deliver free lung checks:*** We have been working in partnership with local authorities, GPs, community and voluntary groups and Public Health on a borough-by-borough basis to deliver the Targeted Lung Health Check Programme – free lung checks for people aged 55-74 who have ever smoked.

  Our approach has led to one of the highest uptake rates in the country. We have delivered over 1,000 scans in Tower Hamlets, just a couple of months

after going live there. The programme started in Barking & Dagenham in July 2022 and will ultimately reach all our boroughs in north east London by March 2027.

- ***Lynch syndrome:*** This is a genetic condition which runs in families and increases the risk of several cancers. We are implementing Lynch Syndrome pathways across north east London for colorectal and endometrial cancers. Patients and their close relatives may be tested for Lynch Syndrome, which can be a risk factor for other cancers, as another mechanism to support with early diagnosis.

- ***Cancer awareness in schools***: Working in partnership with the charity Cancer Awareness in Teens and Twenties (CATTS) to deliver cancer awareness raising sessions within secondary schools to over 2,000 Year 10 and Year 11 pupils.

- ***NHS Galleri Test Interim Implementation Pilot (in partnership with Grail LLC):*** This is a single blood test which can detect a cancer signal for over 50 cancers. It will be offered to residents aged between the ages of 50 and 77 and will focus on areas of higher deprivation, identified by postcodes. This will be a pilot and we are currently in the process of working up timelines for this.

- ***Information and awareness:*** Developing a series of videos to help people take proactive steps to help reduce their risk of cancer: https://www.nelcanceralliance.nhs.uk/top-tips-lower-your-risk-cancer

2.4 **Tackling inequalities within the prevention and early diagnosis element of the patient pathway:** There are significant inequalities within and between our communities in north east London (NEL), and our population has worse health outcomes than the rest of the country across many key indicators. Health inequalities are linked to wider social and economic inequalities. Reducing health inequalities in cancer prevention, awareness and screening is a key priority.

2.5 Work to reduce inequalities in cancer prevention and awareness includes:

- ***Womb Cancer****:* We are working in partnership with The Eve Appeal (a leading UK charity raising awareness of, and funding research for, gynaecological cancers) on a campaign called 'You Need to Know' which aims to increase awareness of womb cancer amongst Black African, Black Caribbean and South Asian women in North East London. Watch a local volunteer here: https://youtu.be/qSAIoJX93Nk?si=hKefjcCKe9TDrqZN

- ***Liver Trucks:*** Community liver health vans are coming to north east London. They offer a free, simple, non-invasive test to people aged 35-70 who may be at increased risk of liver disease, based on their medical history, which will help faster diagnosis for people in areas of deprivation.

- ***Cancer, It's Not A Game:*** This is an awareness campaign for prostate, bowel, lung, and stomach cancers, in partnership with brand and marketing agency Mobas, which uses sport to engage with men in the more deprived areas of north east London. This work has been shortlisted for an HSJ Award. Watch a patient story here: https://youtu.be/V1NxwkIeqNM

- ***Jewish Population:*** North East London Cancer Alliance is working on a cancer awareness project which supports our local Charedi Jewish community. The project provides funding to a local charity, Acheinu Cancer Support (ACS), to drive a programme of cancer awareness, engagement events and communications across north east London

- ***Engaging with the 'White Other' population:*** Working with Claremont communications team, we delivered a series of ten focus groups in the Polish, Lithuanian, Turkish and Turkish Cypriot communities to understand knowledge of and barriers to cancer screening within these communities

2.6 **Cancer screening:** uptake remains a challenge nationally and this is another priority for the work of the cancer alliance. There is low uptake across London as a whole, and we are working to improve the data, especially the breakdown of those not attending so we can tailor our activity. We have a Prevention, Awareness Screening Delivery Group, which is chaired by Matthew Cole, Director of Public Health at London Borough of Barking and Dagenham. The Group is working on a range of local initiatives to address the low uptake of **bowel, breast, and cervical screening**.

2.7 **Partnering with Public Health, Local Authorities and Charities to increase screening:** We have a range of place-based initiatives and NEL wide programmes to boost uptake of bowel, breast, and cervical screening. Work includes:

- **Best For My Chest**: partnering with leading LGBTQI+ cancer charity, OUTpatients to deliver a breast screening campaign aimed at the LGBTQI+ community which features local volunteers. Read a story from one of the local volunteers and watch a video: https://youtu.be/5MfZAlguSKk

- **Bowel screening for the Africa population in City and Hackney:** partnering with the Community African Network to deliver bowel screening and bowel cancer awareness. We have also developed a patient story which you can watch here: https://youtu.be/ieHkvyh5kT8

- **Muslim Sisterhood**: partnering with the Muslim Sisterhood to encourage young Muslim women to attend cervical screening. Our video has received over 230,000 views: https://youtu.be/ie0AnarOwOo?si=LPKkr5wwKlD7jP8w

- **Breast screening for people with a severe mental illness:** Increasing uptake of breast screening for residents with a serious mental illness in Barking and Dagenham, Havering, and Redbridge by reducing barriers to access.

- **Population awareness:** partnering with Community Links, Public Health and Local Authorities to deliver cancer screening awareness (breast, bowel and cervical) directly to communities across north east London through face-to-face events at community centres, including libraries, places of worship and shopping centres.

2.8 Appendix B shows a full list of current and planned awareness programmes of work in north east London to help reduce health inequalities, increase awareness and uptake of screening, and achieve early diagnosis, when cancer treatment is simpler

and more likely to be effective.

3.0 Diagnosis

3.1 Once a patient has been referred from their doctor for a cancer diagnosis, we want to make that sure that their experience is as quick, effective, and consistent as possible. This includes identifying and introducing innovative solutions such as using the latest technology, reducing the backlog, improving waiting times and providing diagnostic results more quickly.

3.2 Waiting times are national NHS constitutional standards and an important way of demonstrating timeliness of the diagnostic and treatment element of the patient pathway. There have been some recent changes to cancer performance standards, modernising and simplifying them from ten standards to three, with a focus on 28 days faster diagnosis (diagnosis or ruling out of cancer within 28 days of referral). The changes ensure people are diagnosed and able to start treatment as quickly as possible.

In order to deliver against the 28-day Faster Diagnosis Standard, our Trusts need to meet key timed milestones for each of the tumour sites, known as the **Best Practice Timed Pathway**. In particular, we are currently monitoring both colorectal and prostate pathways, as these represent some of the highest referral rates into acute hospitals nationally.

3.3 **Reducing the backlog and waiting times:** North East London Cancer Alliance is performing better than the national average in terms of the backlog (the number of patients waiting over 62 days). The latest figures show that this is 6% of the overall 62-day patient tracker list (PTL) for north east London, against a national average of 9%.

Barts Health NHS Trust has sustained backlog improvements ahead of trajectory and is also performing above the national position. Although Barts Health remains in Tier 2 for cancer performance, the Faster Diagnosis Standard (diagnosis or ruling out of cancer within 28 days of referral) position was also achieved in the last data report.

Homerton Healthcare Trust is one of the best performing in the country in terms of patients who are waiting more than 62 days for treatment. It is also recording figures of nearly 100% for patients starting treatment within 31 days of a treatment plan being agreed, higher than the average for both London and the whole of the country.

Barking, Havering and Redbridge University Hospitals Trust, according to the latest figures released by NHSE, is performing well in terms of recovery and just missed out on achieving the Faster Diagnosis Standard (72.2% achieved against a target of 75%).

3.4 **Using the latest technology in diagnosis:** We continue to explore innovative techniques to boost diagnostic capacity for our residents, as well as use tools to speed up a diagnosis. These help patients to receive a quicker, more effective service and, in many cases, one which is less invasive. For example:

> ***Robotics****:* King George Hospital is the first in the country to offer a robotic colonoscopy machine. Patients benefit from a painless and non-invasive procedure compared to a traditional colonoscopy and do not require any

sedation meaning faster recovery.

***Colon Flag**:* a new NHS-approved blood analysis tool to improve the speed of diagnosis of bowel cancer for our local residents. It works alongside other bowel tests using blood samples to spot cancer earlier.

***Cytosponge**:* a quick, easy test which is a pill on a string and is an alternative to endoscopy. It can help detect and monitor Barrett's oesophagus and, in rare cases, oesophageal cancer.

Artificial Intelligence (AI) for Chest X-Ray: Trusts across north east London have supported the development of an innovative solution for immediate AI reporting.

3.5 **Boosting diagnostic capacity*:*** Designed by patients for patients, the Mile End Early Diagnosis Centre is an innovative collaboration between all three acute providers (Barts Health; Barking Havering and Redbridge University Hospitals Trust; and Homerton Healthcare), which is delivering over 16,500 vital cancer tests annually. We have recently added a new Magnetic Resonance Imaging (MRI) suite, which is providing an extra 4,500 scans a year for all residents across north east London. This work has been shortlisted for an HSJ Award.

This is a step on the journey to becoming a Community Diagnostic Centre (CDC) and has recently secured additional funding. Work is also progressing well on our other CDC for north east London, which is at Barking Community Hospital.

3.6 **Teledermatology - the use of static digital images to triage, diagnose, monitor or assess skin conditions:** Implementation of the teledermatology project is successfully supporting providers to manage demand and reduce the backlog, and we are developing a photography hub in the Community Diagnostic Centre.

3.7 **Non-Symptom Specific (NSS) pathway:** The rollout for patients with non-symptom specific suspected cancer was completed and embedded ahead of the national expectation of 100% by March 2023. Symptoms considered 'non-specific' include unexplained weight loss, fatigue, abdominal pain or nausea; and/or a GP 'gut feeling' about cancer. The pathway helps patients to get a faster diagnosis and also helps reduce the number of times a GP sees a patient before a referral, or having to make a referral on multiple pathways.

4.0 Treatment

4.1 If a patient does have cancer, we want to reduce any differences in cancer treatment, so that all residents in north east London receive the best possible care.

4.2 **Helping patients prepare for cancer treatment:** Over 600 patients have benefited from prehabilitation interventions resulting in increased fitness for treatment, reduced consequences of treatment and length of stay in hospital. Watch a patient who has benefited from this treatment: https://youtu.be/AocMJd4YNA8?si=7cw9Z6I8hiiiKfCV

4.3 **Improving Multi-Disciplinary Team Meetings**: These are central to the management of patients with cancer, and they were introduced over 20 years ago to reduce variation in decision-making and access to best care for cancer patients. Our

work to improve these is an example of true collaboration across north east London, with teams from each Trust coming together to help improve outcomes for patients.

4.4 **Making sure patients get the support they need at each stage of their treatment journey:** We have developed a personalised cancer care pathway for patients so they can understand what support is available for them at every stage of their journey, from diagnosis through to treatment and post treatment. This is shown in Appendix C.

4.5 **Clinical animations**: We are developing high quality, easy to understand clinical animations, in order that complex treatment options, (including clinical trials), are made more accessible to patients.

4.6 **Workforce review:** Reviewing oncology workforce and looking to identify any areas of improvement for treatment for local patients.

4.7 **Patient information:** We have developed patient videos explaining chemotherapy and immunotherapy treatment, along with what they should look out for in terms of potential side effects from the treatment.

5.0 Support for people living with cancer

5.1 We believe that all residents in north east London living with cancer should have access to high quality care that is personalised to their individual needs. This is from the moment a cancer is diagnosed, all the way through to end of treatment and follow-up.

5.2 Our aim is to improve patient outcomes and experience whilst reducing variation for all people affected by cancer. Patients, carers and their families, remain at the very heart of all we do.

5.3 Examples of work include:

- ***Remote Monitoring System (RMS) for patients:*** All three acute trusts have procured, upgraded and installed the required Somerset Remote Monitoring System. Barts Health has operationalised RMS and has gone live for colorectal and prostate patients. Barking, Havering and Redbridge University Hospitals Trust, and Homerton Healthcare have also gone live with breast, prostate and colorectal.

- ***Psychosocial:*** We are working with our partners to ensure that appropriate psychological support is available to all people affected by cancer and their significant others. We are implementing our 2023/2024 Psychosocial Development Plan to address inequities across the system and improve psychosocial support for people across north east London.

- ***Working with local authority, community and voluntary partners:*** Through our many partners at a place-based level across north east London, there is a wide variety of non-medical support for cancer patients, and we are working with these partners to promote the services available so patients are aware of these and can access them. These services cover things like financial advice, benefits, housing, employment, bereavement, healthy living, and social prescribing.

6. End of life care

6.1 All cancer patients that enter the cancer pathway are offered a holistic needs assessment (HNA) at key points in their pathway. These key points include an HNA at the point of diagnosis, HNAs at the end of the treatment episode, and an HNA when patients enter either follow-up, curative discharge, supportive palliative care or end of life care.

6.2 The North East London Cancer Alliance's personalised cancer care programme is working with NEL ICB's End of Life Programme to actively link key cancer End of Life Care activities for local patients.

6.3 In 2022/23 the Alliance invested in piloting an Advanced Care Planning nurse that operated with the Enhanced Supportive Team at Barking, Havering and Redbridge University Hospitals Trust (BHRUT). The programme looked into establishing an Advance Care Planning clinic which is a safe space for patients and their families to have in depth conversations about their future care.

Discussions on resuscitation status and patients, and their family are educated about this means. Conversations so far have varied, from detailed funeral plans to what death is like, to spirituality and belief in afterlife. The team at BHRUT are linked to the wider ICB End of Life programme.

6.4 Most recently, the North East London Cancer Alliance has shared with the ICB's End of Life programme, a funding opportunity from Macmillan regarding investing in transformational adult end of life care (cancer and non-cancer).

7.0 Engaging with our local communities

7.1 The most effective way to reach individual communities is working with them directly and with local partners to produce support which meets their requirements and speaks to them individually. More information about our approach to engaging with communities is in appendix D.

7.2 To support this work, getting patient input is a key part across all of our projects and we have a Patient and Carer Voice in Cancer group set up which is made up of local patient and carer representatives. You can hear from some of them here: https://www.nelcanceralliance.nhs.uk/pcvc/representatives

7.3 We also have a communications strategy in place to help engage with our stakeholders, along with an innovative data programme to help us make informed decisions to support our local population. More information on this is in appendix E.

8.0 Conclusion

8.1 Improving local cancer services and reducing inequalities remain at the heart of what we do across north east London. To successfully implement the NHS Long Term Plan and our local cancer delivery plans for this financial year and beyond, we need to work together with all health and care partners both at a local level and across north east London as a whole.

8.2 The ICB Board is asked to recognise the continued progress made by the North East London Cancer Alliance, in spite of both national and local challenges. There is much work still to do, but we have a strong team in place, and we are working on a range of initiatives at every stage of the cancer journey to improve patient outcomes.

8.3 Proposed questions for discussion:

- How can we further engage and work together with local partners to achieve better health outcomes for our local population?
- How can we better link in with other health conditions and health initiatives across north east London?
- What further support can the North East London Cancer Alliance and the NEL ICB provide each other to achieve common objectives?

9.0 Attachments

9.1 List appendices as:

- Appendix A: About the North East London Cancer Alliance
- Appendix B: Current and Planned Awareness Campaigns
- Appendix C: Personalised Cancer Care Pathway
- Appendix D: Our approach to engaging with local communities
- Appendix E: Supporting the work across the entire pathway

10.0 End

Author: Femi Odewale, Managing Director,
North East London Cancer Alliance

Date report produced: 19 October 2023

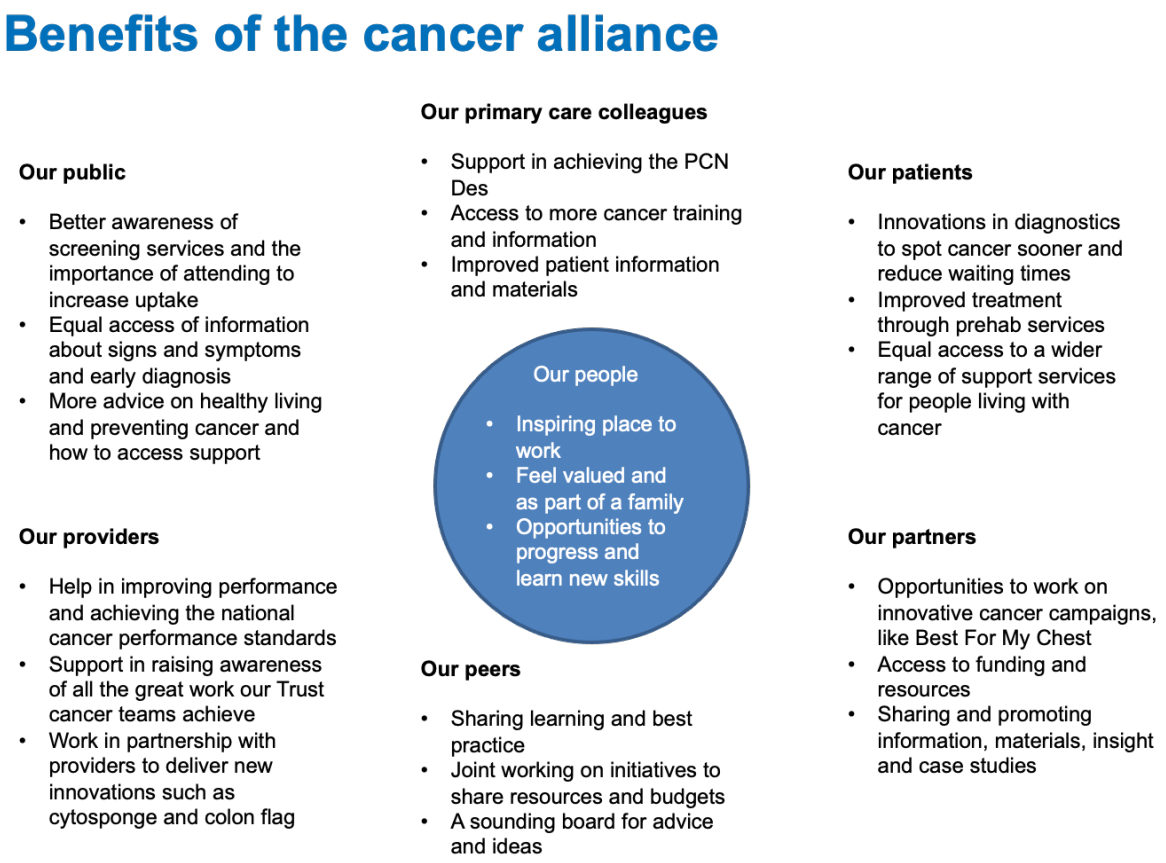
Appendix A: About the North East London Cancer Alliance

Cancer alliances are nationally funded to ensure and demonstrate commitment to improving cancer outcomes. North East London Cancer Alliance receives ring-fenced funding of c£12.1m per year, of which £3.2m is targeted funding allocations for national programmes which are implemented locally.

The North East London Cancer Alliance was formed on 1 April 2020 and is one of 21 cancer alliances across England. We help to improve cancer prevention, diagnosis, treatment and care for local residents. To do this, we work with patients, residents, carers, hospitals, GP practices, health and care professionals, local authorities and community and voluntary organisations across north east London.

The North East London Cancer Alliance is part of the North East London Integrated Care System and is committed to improving cancer outcomes and reducing inequalities for local people. Our aim is to ensure that all residents have equal access to better cancer services so that we can:

- Prevent cancer
- Spot cancer sooner
- Provide the right treatment at the right time
- Support people and families affected by cancer



The North East London Cancer Alliance supports the North East London Integrated Care Board in improving the health and wellbeing for the local population, reducing health inequalities. Our roles and responsibilities are:

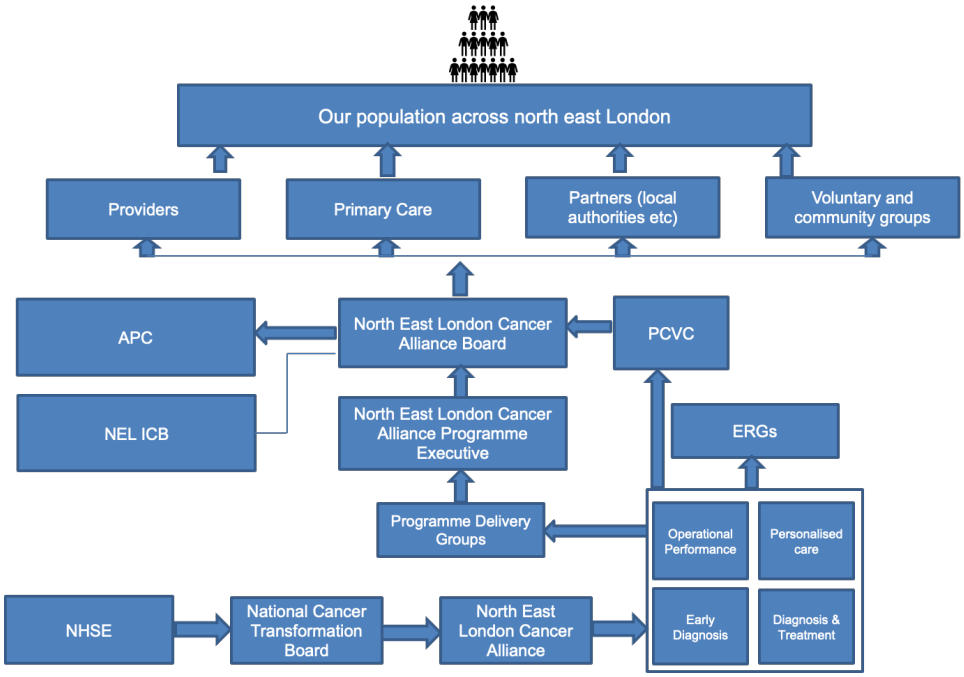
- **Whole-system and whole-pathway delivery:** The NEL cancer alliance works with provider collaboratives and other system partners to improve the delivery of cancer pathways, including performance against the operational standards for cancer. We work across the whole pathway, providing the link to partners including: prevention, screening and public health services; primary care; diagnostic networks; operational delivery networks (e.g. for radiotherapy); community diagnostic centers; end of life care providers. Alliances will also ensure alignment with wider system plans, for example on workforce, health inequalities, digital and research innovation.

- **Clinical leadership:** The NEL Cancer alliance facilitates clinical expert groups to ensure clinical leadership for specific cancer pathways within local system(s.)

- **Strategic commissioning:** The NEL cancer alliance has a key role in strategic planning and provides **advice** to the ICB(s) on the commissioning of routine and specialised cancer services, including associated diagnostic services, ensuring there is sufficient capacity to meet the needs of people with cancer or suspected cancer.

- **Operational performance:** The NEL Cancer alliance is responsible for monitoring operational performance and identifying, diagnosing and acting on areas requiring improvement. This includes leading local pathway re-design and other support to improve operational performance.

We work with partners across the North East London Integrated Care System:



Appendix B: Current and Planned Awareness Campaigns

Current campaigns:

Campaign	Target Tumour	Target audience
It's Not a Game	Bowel, stomach, prostate and lung.	White and Black men from the more socio-economically deprived areas
No Time for Cancer	Breast	All women of screening age
Best for my Chest	Breast	LGBTIQA+ community
You Need to Know	Endometrial – to extend to all gynae cancers	Black and South Asian women (post-menopausal)
Tell Me About It	All cancers (symptom awareness)	Older people
Muslim Sisterhood	Cervical	Muslim women of screening age (primarily 25 – 40 year olds)
Awareness in schools	All cancers, including sun safety	Year 10/11 pupils NEL wide
Awareness in the Charedi population	All cancers, including specific genetic testing awareness	Charedi Jewish population

Planned Campaigns:

Campaign	Target Tumour	Target audience
It's Not a Game	Bowel, stomach, prostate and lung.	White and Black men from the more socio-economically deprived areas
No Time for Cancer	Breast	All women of screening age
Best for my Chest	Breast	LGBTIQA+ community
You Need to Know	Endometrial – to extend to all gynae cancers	Black and South Asian women (post-menopausal)
Tell Me About It	All cancers (symptom awareness)	Older people
Muslim Sisterhood	Cervical	Muslim women of screening age (primarily 25 – 40 year olds)
Awareness in schools	All cancers, including sun safety	Year 10/11 pupils NEL wide
Awareness in the Charedi population	All cancers, including specific genetic testing awareness	Charedi Jewish population

Appendix C: Personalised Cancer Care Pathway

Your personalised cancer journey

1 Cancer Diagnosis

Your GP, hospital consultant or practice nurse will give you your results and explain what they mean.

Treatment Plan

Agreement on what treatment will be best for you, along with timelines and support. Please make sure you attend all your appointments.

Holistic Needs Assessment

A simple questionnaire to highlight your most important issues and can help create your care and support plan.

Personalised care and support plan

Provides your personal health and wellbeing information and support. This could include connecting with others in a similar situation to yours and advice on telling family and friends.

Prehabilitation

Service to improve your mental health and wellbeing, your diet and your fitness, helping you be as healthy as possible before your treatment, which gives you the best chance of success and recovery.

2 Treatment begins

Your cancer treatment should begin within 2 months of your cancer diagnosis.

Reducing the impact of treatment

Helping you deal with common side effects of cancer treatment, such as lymphoedema, helping you improve your quality of life.

Health and wellbeing events

Helping you connect with others going through cancer treatment

Psychosocial support

Services and activities such as counselling, education, spiritual support, group support, and other services to improve your health and wellbeing.

3 Post treatment

Following your treatment there is a range of support that you will continue to receive.

End of treatment Holistic Needs Assessment

A follow-up questionnaire to highlight your most important issues and concerns

Treatment Summary

Completed by cancer professionals in your hospital after a significant phase of your cancer treatment. It describes the treatment, potential side effects, and signs and symptoms of recurrence.

Rehabilitation

Helps you restore and maintain physical and mental health and wellbeing after your cancer treatment.

Follow up Treatment Plan

Also known as Personalised Stratified Follow-Up. This is a plan which is personal to you to look after you after your cancer treatment. It includes things like regular surveillance scans or tests, rapid re-access to your cancer team (including telephone advice and support), information about signs and symptoms to look out for which might suggest your cancer has returned.

National Cancer Patient Experience Survey

Following your discharge from hospital after your treatment, you may be invited to take part in a national survey to give your feedback on your care.

Appendix D: Our approach to engaging with local communities

NEL is a diverse, vibrant and thriving part of London with a rapidly growing population of over two million people, living across seven boroughs and the City of London.

Just over half (53%) of our population are from ethnic minority backgrounds – we know that significant health inequalities exist between ethnic groups; this was highlighted and exacerbated by Covid-19.

Nearly a quarter of local people live in one of the most deprived 20% of areas in England; and overall, among our boroughs, Barking & Dagenham is ranked 21st, Hackney 22nd, Newham 43rd, and Tower Hamlets 50th most deprived of all (312) England local authority areas.

There are significant inequalities within and between our communities in NEL, and our population has worse health outcomes than the rest of the country across many key indicators. Health inequalities are linked to wider social and economic inequalities

The most effective way to reach individual communities is working with them directly and with local partners to produce support which meets their requirements and speaks to them individually:

- Focus groups made up of community members
    - Understand barriers (e.g. fear, myths, lack of trust, cultural)
    - Get feedback on plans for the campaign
    - Provide input into design of the campaign

- Community members to actively participate in the campaign - e.g. as models for posters, appearing in videos, providing testimonials etc.

- Working with local partners and charities - e.g. OUTpatients

- Getting patient stories to share as a follow up

- Being brave - understanding the risks, e.g. negative feedback from other groups

Appendix E: Supporting the work across the entire pathway

Communications and engagement: We want to keep all our stakeholders updated on the work that we do across north east London. We do this via the news section of our website, our social media channels, newsletters and by working with local communications, engagement and community partners across north east London.

We have a communications and engagement strategy in place to support all the work across the cancer alliance. Recent communications highlights include:

- We were pleased to be involved in UK Black Pride for the first time this year. The event took place in Queen Elizabeth Olympic Park, Newham on 19 August. 2023.

- Article and case study to promote the fact that North East London Cancer Alliance has been reported as the top alliance in the country for Ovarian cancer five-year survival rates

- Attended an information stall at Whipps Cross Hospital and the Redbridge Disability Festival, speaking to over 500 residents across the two events. Working on a new patient case study as a result of a contact made.

- Promoted the positive feedback from patients on attending their targeted lung health check - 95% rate their lung health check experience as either 'very good' or 'good

In the last year we have been growing our communications channels, with an established website, YouTube channel, and Twitter (X), LinkedIn, Facebook and Instagram accounts. We are also working with accessibility teams to make our content as accessible as possible, including using language tool ReciteMe, producing offline versions of our material and translating assets into key languages.

Innovating in information – NEL CAIN: This is a project to improve access to data for the North East London Cancer Alliance to enable decisions to be made more effectively and quickly about where further work or support is needed across the system.

North East London
Integrated Care Board

NHS North East London ICB board

29 November 2023

Title of report	Financial overview - Month 7 2023-24
Author	Steve Collins, Director of Finance
Presented by	Steve Collins, Director of Finance
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 October 2023 position with an adverse variance to plan of £16.5m for the ICB as part of a £87.2m adverse variance for the ICS. • The report includes a review of efficiency plans and impacts from inflation, staffing, industrial action and other operational pressures. • The ICS has developed a formal finance recovery plan (FRP) to bring the current run rate of expenditure closer to plan. At month 7, factoring into account the impact of industrial action, the ICS is £8.3m adverse to its FRP trajectory. • The ICB and ICS submitted an update to the forecast position to NHSE after month 7. This showed a movement from a breakeven forecast to a deficit position of £31.2m. • The Board are asked to note the month 7 position and the update to the financial position submitted to NHSE.
Action required	The Board is asked to note the contents of the report and the risks to the financial position.
Previous reporting	ICB Finance, Performance and Investment Committee, ICB Audit and Risk Committee and ICB Board.
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, industrial action, operational pressures and lost income for providers. The ICB risk rating for finance is 20. A finance recovery plan has been developed. Updates will be given to the ICB Board on delivery against the plan.

1. Purpose of the Report

The purpose of the report is to update the ICB Board on the month 7 financial position and the risks associated with delivery of the Integrated Care System (ICS) and ICB financial plan.

The ICB Board is recommended to note information in the finance overview.

2. Month 7 Finance Overview

The month 7 year-to-date position across the North East London (NEL) system is a overspend variance to plan of £87.2m. This is made up of a provider overspend variance of £70.7m with an ICB overspend variance of £16.5m. The costs of industrial action costs are currently included in this figure and are contributing to the overspend position.

At month 7 the ICS as a whole is still forecasting to deliver a breakeven plan in line with the operating plan and national reporting protocol. However, as reported previously the year-to-date position indicates a substantial risk to delivery and a formal financial recovery plan (FRP) developed. The FRP assessed the impact of cost improvement schemes (CIPs) and other corrective actions, still leaving a potential system year-end gap of £55m.

After month 7 closedown NHS England (NHSE) requested that systems submit a return to them to provide an update of the forecast position for the system. The revised forecast for NEL ICS is £31.2m. The revised forecast includes additional non-recurrent allocations issued to systems (including funding for industrial action), the reduction in elective recovery targets and Electronic Funds Transfer (EFT) payment flows and guidance on System Development Fund (SDF) programme funding and ring-fenced dental flexibilities.

The ICB revised forecast is expected to be a surplus of £15.1m with a total provider deficit of £46.3m.

2.1.1 ICS Month 7 and Forecast Position

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

Organisations	Year to date			Reported Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
BHRUT	(3.5)	(27.5)	(24.0)	(0.2)	(0.2)	0.0
Barts Health	(16.2)	(49.8)	(33.6)	(27.8)	(27.8)	0.0
East London NHSFT	1.1	(3.2)	(4.3)	5.4	5.4	0.0
Homerton	0.1	(8.4)	(8.5)	0.2	0.2	0.0
NELFT	3.5	3.2	(0.3)	7.0	7.0	0.0
Total NEL Providers	**(14.9)**	**(85.6)**	**(70.7)**	**(15.3)**	**(15.3)**	**0.0**
NEL ICB	9.0	(7.5)	(16.5)	15.4	15.4	(0.0)
NEL System Total	**(6.0)**	**(93.1)**	**(87.2)**	**0.0**	**0.0**	**0.0**

All providers and the ICB are reporting year-to-date pressures at month 7, 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 £113m (or 80.4% of the total cap). The year-end submitted forecast on agency spend is £159.2m (£18.6m above the cap). However, the month 7 run rate on agency spend suggests that year-end spend could be in the region of £198.7m. This is an upward trajectory compared to previous reporting periods.
- **Impact of Industrial action** – Providers have reported year-to-date pressures as a result of the costs of industrial action. At month 7 the year-to-date direct costs of industrial action are just over £18m. This has impacted the Trusts both in terms of the costs incurred on backfill butt also on their ability to deliver elective activity.
- **Efficiency and cost improvement plans** - the total system efficiency and cost improvement plan at month 7 is £146.5m. Of this £121.7m has been delivered, leaving a year-to-date under delivery against plan of £24.8m (£19.9m providers and £5m ICB). The year-end forecast of efficiencies is an under delivery across the system of £40.4m.
- **FRP** – For the purposes of reporting to NHSE the ICB recategorized efficiencies in line with the system approach to efficiencies. To hit its expected year-end surplus the ICB has a challenging FRP stretch target and will deliver non-recurrent, non cash releasing savings in excess of the savings target. To hit its expected surplus position the ICB will deliver a total of £103.4m savings (efficiencies reported to NHSE plus FRP savings). 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 £14.5m. Part 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 balance is as a result of capital overspends

at Homerton Healthcare and Barts Health. Within the ICB position there is a pressure of £1.2m relating to the capitalisation of lease costs.

2.1.2 – ICB Year-to-date and forecast position

The ICB year-to-date position is an adverse variance to plan of £16.5m, 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, primarily in Continuing Healthcare (CHC), prescribing and programme wide / corporate areas of spend. Additionally, there are reported run rate overspends in prescribing (relating to price and activity pressures) and mental health (activity driven services, such as female Psychiatric Intensive Care Units (PICUs), section 117 and adult placements). In contrast, there is a year-to-date £2m 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	(16.5)	0.0
Acute	(0.9)	(1.3)
Mental Health	(2.7)	(5.2)
Community Health	0.6	1.6
Continuing Care	(7.9)	(11.8)
Primary Care - Co Commissioning	(0.0)	0.0
Primary Care - DOPs	2.0	0.2
Primary Care - Other	(16.6)	(27.2)
Running Costs	(0.0)	0.0
Programme Wide Admin (Programme Corporate)	(2.3)	1.3
Other	11.4	42.4
Total Variance to Plan	**(16.5)**	**0.0**
Planned Surplus	9.0	15.4
(Deficit) / Surplus	**(7.5)**	**15.4**

The ICB is facing a run rate pressure of an adverse variance to plan of £16.5m. An extrapolation of the current run rate suggests that the ICB has a potential risk to the delivery of the planned surplus of circa £55m which would result in a year-end deficit of £39m.

The forecast position assumes that additional stretch measures and opportunities identified through the FRP could result in an ICB shortfall to plan of £7.5m. This will continue to be mitigated by reviewing existing investments and programme spend to ensure that the ICB hits its control total.

2.1.3 – Month 7 Performance and FRP Trajectory

The FRP trajectory requires an improvement on the monthly run rate position but still contains a risk to the financial position of £55m. There was an expectation in the FRP that there would be an in-month breakeven position at month 7.

The table below shows the performance against the FRP by organisation.

Organisation	M1-7 Actuals £m	FRP		Industrial Action (IA) Impact	
		FRP Expected M1-7 Actuals £m	Variance from FRP £m	M1-7 Adjusted Actuals (IA) £m	Adjusted Variance from FRP £m
BHRUT	(27.5)	(17.6)	(9.9)	(24.6)	(7.0)
Barts Health	(49.8)	(42.0)	(7.8)	(41.9)	0.1
East London NHSFT	(3.2)	(1.8)	(1.4)	(2.9)	(1.1)
Homerton	(8.4)	(6.7)	(1.7)	(7.1)	(0.4)
NELFT	3.2	3.5	(0.3)	3.5	(0.0)
Total NEL Providers	**(85.6)**	**(64.5)**	**(21.0)**	**(73.0)**	**(8.4)**
NEL ICB	(7.5)	(7.6)	0.1	(7.5)	0.1
NEL System Total	**(93.1)**	**(72.2)**	**(20.9)**	**(80.5)**	**(8.3)**

The month 7 year-to-date deficit is £93.1m, the FRP assumed that the month 7 year-to-date deficit would be £72.2m. This means that system financial performance was £20.9m above the FRP trajectory.

However, industrial action has impacted on the overall financial position. Once the impact of industrial action is removed from the year-to-date position this results in a year-to-date deficit of £80.5m which is £8.3m adrift from trajectory.

2.1.4 – Post Month 7 Revised Forecast Outturn Position

After the month 7 financial position was submitted, NHSE issued guidance and templates to submit a revised forecast outturn for the ICB and ICS.

The revised forecast system deficit for 23/24 is £31.2m. This has been agreed with system partners as a realistic year-end forecast. The ICB Board has held an extraordinary Board meeting to approve this.

The forecast position by organisation is shown in the table below.

	ICS £'m	BHRUT £'m	Barts £'m	ELFT £'m	Homerton £'m	NELFT £'m	ICB £'m
FRP	**-54.8**	**-14.2**	**-55.5**	**5.4**	**-5.1**	**7.0**	**7.5**
Revised FOT	**(31.2)**	**(14.2)**	**(42.6)**	**5.4**	**(1.9)**	**7.0**	**15.1**
Movement from FRP	23.7	0.0	12.9	0.0	3.2	0.0	7.6

Original plan	0.0	(0.2)	(27.8)	5.4	0.2	7.0	15.4
Movement from plan	(31.2)	(14.1)	(14.8)	0.0	(2.1)	0.0	(0.2)

The movement from the FRP potential deficit of £55m is as a result of an additional allocation from NHSE for industrial action and other non-recurrent measures plus an expected benefit as a result of an adjustment to the elective recovery (ERF) threshold.

Other assumptions included in the revised forecast include;

i. The underspend on delegated budgets for dental can be included in the revised forecast as a benefit to the bottom line.
ii. Subject to some exceptions underspends against SDF and other programme budgets can be used non-recurrently to support wider system financial performance.

iii. Efficiencies and FRP stretch assumptions are assumed to be in line with month 7 and will be required to hit the revised forecast position.

Providers have included an assumption on the financial risk of continued industrial action. This is estimated to be £23m and would impact the system's ability to hit the revised forecast position.

The ICS and ICB will continue the work on the unpalatable options to address the remainder of the gap between breakeven and the revised forecast position.

3. Summary Month 7 Financial Position

The ICS has reported year-to-date variance to plan of £87.2m at month 7, in line with NHSE reporting protocol a forecast breakeven position is reported at year-end. Delivery of the FRP is critical to achieving the financial target set.

The ICB Board is asked to note the month 7 financial position and the revised forecast of £31.2m submitted to NHSE after month 7 closedown.

North East London
Integrated Care Board

NHS North East London ICB board

29 November 2023

Title of report	Performance report
Author	Clive Walsh, Interim Director of Performance
Presented by	Steve Collins, Director of Finance
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 August 2023. For Urgent and Emergency Care (UEC) September 2023 data is available. The total waiting list in planned care has fallen in August 2023, however, it rose in five of the previous six months. The numbers of very long waiting patients (over 78 weeks) continues to fall. The total waiting list and number of patients waiting greater than 65 weeks are above trajectory. Industrial action (IA) by medical staff last took place 2–4 October 2023. Action by a variety of UNITE members ran between 6–17 November 2023 and is anticipated from 4–10 December 2023. The likelihood of regular strike action by consultant and junior medical staff has now reduced. The IA has led to a loss of planned care capacity and contributed to the failure to meet the national requirement to treat all patients waiting over 78 weeks by 30 June 2023. The number of patients waiting more than 62 days for cancer treatment rose in August 2023 but remains below the trajectory level. Barts Health has moved into a Tier 2 position with additional NHS England support. IA had an impact on Barts Health performance as staff were redeployed to support urgent operational pressures. NHS England has revised the existing cancer standards to concentrate on the measurement of three key factors. The verified position for September 2023 shows a small deterioration against the 4-hour emergency department standard with small underachievement against the overall trajectory. The system continues to be supported in Tier 1 (highest risk) for UEC services for 2023/24 by the national UEC team.
Action required	The Board is asked to note the report.
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 and the UEC Programme Board. The report will be considered by the Finance, Performance and Investment Committee (FPIC) and the Quality, Safety and Improvement Committee (QSIC) at their meetings on 30 November and 6 December 2023.

Next steps / onward reporting	Further action from the Board can be picked up at the FPIC meeting on 30 November 2023
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 NHSE-London study on the views of London residents on UEC services has been presented to the UEC Programme Board. A national study to assess the effect of IA on planned care and any resulting harm to patients from delayed treatment has not yet reported. To obtain a measurable effect, large national data sets are required.
Impact on finance, performance and quality	There have been more than 30 days of IA affecting patients (particularly for ambulance services and medical staffing in north east London), and the mitigating actions have increased costs, and resulted in extensive cancellation of planned care patients. The prospect of continued IA by medical staff is reducing. To fund the increased costs of IA nationally, the NHS has been asked to undertake an urgent winter planning exercise, reviewing the end-of-year performance trajectories and financial position.
Risks	The risks and issues are described against the relevant performance domains. The top three risks in the Chief Finance and Performance Officer 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 board. 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 fell in August 2023, while with the numbers of very long waiting patients (greater than 78 weeks) continues to fall. The total waiting list is now approximately 11% above the trajectory level, as the plan was for a

reduction in this period. All London ICBs have shown an increase in the number of patients waiting more than 65 weeks since March 2023, and started the year with similar reducing trajectories.

2.2 The Urgent and Emergency Care (UEC) domain shows a variable position in UEC factors in September. The unvalidated position in October against the 4-hour standard is 69.4%, and this is 0.4% below the trajectory (generally increasing month-on-month). The North East London (NEL) system has been designated as Tier 1, requiring the highest of intervention and support from the national UEC team. It is expected that Tier 1 status will complement the existing SOF4 process for Barking, Havering and Redbridge University Hospitals Trust (BHRUT), and a review was undertaken with NHS England (NHSE) on 10 November 2023. The date for BHRUT to exit SOF4 status has yet to be agreed.

2.3 The number of patients waiting more than 62 days for cancer treatment has decreased, and in August is 5% below trajectory (in June it was 11% below). The system has entered Tier 2 status for cancer delivery, with fortnightly reviews with NHSE.

2.4 Nationally, ICBs and Trusts have been asked to review their performance trajectories for the remainder of the year. The area of significant change will be in the expected number of patients waiting more than 65 weeks.

3.0 Performance in August 2023 and September 2023

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

3.2 NEL is designated as a Tier 1 system for UEC, requiring the highest level of support and intervention from NHSE. 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. A visit by the National Director for UEC services to King George Hospital and locality took place on 31 August 2023 and a further visit to the Romford site is scheduled in December 2023.

3.3 The Integrated Care System (ICS) submitted the first iteration of its Winter Plan in September 2023. On 8 November 2023, NHSE issued revised planning guidance following several periods of industrial action which have been held by ambulance, nursing, radiography, medical and support staff, from January through to October 2023. The area of significant change will be the March 2024 position for patients waiting more than 65 weeks. The previous trajectory was to reduce this to zero. Any agreed change will be reflected in future Board performance reports.

3.4 Previously, the Board was notified of changes to the nationally reported cancer standards. These will be implemented from October 2023, with the first data reported in December. NEL is monitoring these standards in “shadow” form from the August 2023 data, and these three core measures are reported in the pack:
- The 28-day Faster Diagnosis Standard (FDS) (75%)
- One headline 62-day referral to treatment standard (85%)
- One headline 31-day decision to treat to treatment standard (96%)

4.0 Risks and mitigations

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

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 standard set of Powerpoint slides which covers the detail of each of the performance domains and is the main body of the performance report. 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: 16 November 2023

Planned Care Recovery & Transformation – August 2023

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published August-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Planned Care	Total Waiting List (volume)	⊗	191,930	213,219	▼	
	Waiting List >104 Weeks (volume)			8	⇔	
	Waiting List >78 Weeks (volume)			206	▼	
	Waiting List >65 Weeks (volume)	⊗	1,317	2,609	▲	
	Inpatient Elective Activity (% 19/20 BAU)	⊗	102.40%	93.97%	▼	
	Consultant Led Outpatient Attendances (% 19/20 BAU)		103.96%	103.85%	▼	
	Consultant Led First Outpatient Attendances (% 19/20 BAU)		107.90%	100.40%	▼	
	Consultant Led Follow Up Outpatient Attendances without procedure (% 19/20 BAU)		108.83%	103.49%	▲	

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

Key Headlines

- The overall NEL RTT waiting list decreased (for the first month following sustained growth from Feb-23) in Aug-23 213,219 pathways (-944 pathways from the Jul-23 position), driven by reduction in the outpatient waiting at Barts Health and BHRUT. The inpatient waiting list at Barts Health also fell slightly. The waiting list at Homerton continued to increase in Aug-23 (+1,066 pathways), across inpatient and outpatient lists. All three Trusts above submitted operating plan trajectory for the month.
- There were 8 pathways waiting 2 or more years (>104ww) in Aug-23 (no change from Jul-23) at Barts Health (3 pathways awaiting inpatient treatment and 5 pathways awaiting outpatient treatment).
- The total number of patients waiting 18 months or more (>78 weeks) fell in Aug-23 to 206 pathways (-29 pathways from the previous month, driven by an improved position at Barts Health), 204 pathways at Barts Health, 1 pathway at BHRUT and 1 pathways at Homerton.
- There were 2,609 Pathways >65ww in NEL in Aug-23, an increase of +315 pathways from the previous month, with growth across all three NEL Trusts. BHRUT is the only NEL Trust to achieve against >65ww trajectories YTD.
- In Aug-23, consultant led outpatient appointments were 104% of 2019/20 levels (all outpatient appointments consultant and non-consultant led were 110%). Consultant led follow up appointments without a procedure were 103% of 2019/20 levels (Barts Health 105%; BHRUT 94% and Homerton 113%).
- Total inpatient admitted activity completed at the three NEL Trusts in Aug-23 was 94% of 2019/20 levels (96% day case admissions and 83% ordinary admissions).

Workstream Issues and Risks

- Overall waiting list size
- The number of patients continuing to wait >104 weeks and >78 weeks at Barts Health
- Risk to delivery of the >65ww booking ambition (all patients at risk of breaching >65ww by Mar-24, to have a first outpatient appointment before end Oct-23) and risk to the overarching >65ww position (0 patients to be waiting >65ww by Mar-24), most acutely at Barts Health. There are currently circa 19,000 patients in the >65ww risk cohort across NEL and circa >2,000 patients that are unlikely to have had a first outpatient appointment by end Oct-23.
- Activity volumes and clock-stops not at required levels to significantly impact the waiting list – further impacted by Industrial Action (IA)
- Impact of ongoing IA on recovery, activity and the long waiting position – impact of cancellations, ongoing impact of displacement of activity (incl. impact on admin and scheduling staff), staff morale and 'good-will', as well as to other activities that support waiting list management (incl. outpatient transformation, triage, A&G/R, etc.,)
- Ability to meet and sustain meaningful reduction in follow-up activity, balanced against the waiting list position, non-RTT FUPs, and activity required to stop RTT clocks
- Impact and implications of national programme to increase 'Patient Choice', specifically 'Patient Initiated Mutual Aid' (PIDMAS) at Trust and ICB level within current financial constraints and existing resource allocations, and in context of current capacity challenges, conflicting priorities and waiting list initiatives. PIDMAS went live 31/10.

Mitigating Actions and Next Steps

- Weekly Tier 2 arrangements in place with Barts Health
- Range of actions and innovations at Barts Health to reduce >65ww risk e.g. incl. patient contact and engagement, DMAS, outsourcing, validation and Virtual Lucy (Dermatology pilot)
- PTL growth analysis continues to be undertaken across challenged specialties
- Next tranche of NEL wide D&Q, PTL management and validation peer review to be completed
- Ongoing Trust and site theatre productivity and utilisation programmes, overseen via the NEL Surgical Optimisation Group
- Targeted reduction to improve patient DNA rates and improve efficiencies
- NEL 'Patient Initiated Mutual Aid (PIDMAS) process and volumes to be tested during November following go-live 31/10.
- Referral restrictions lifted at BHRUT. Referral restrictions remain in place for 4 specialties at Homerton. Barts Health are completing restriction review
- Homerton continues to provide collaborative capacity to Barts Health. BHRUT have agreed to provide support to Barts Health and have accepted the transfer of a circa 350 pathways in the >65ww risk cohort in the most challenged / at risk specialties (e.g. ENT, Oral Surgery, Respiratory, Vascular) since mid-Oct. Ongoing rolling weekly volumes are be agreed in early Nov.

Governance

- NEL Planned Care Recovery and Transformation Programme Bi-weekly assurance meetings held with NHSE region and Barts Health
- NEL Planned Care Board and APC Governance

Outpatient Transformation – August 2023

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published August-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Outpatient Transformation	A&G/Specialist Advice (volume)	✓	20,931	28,545	▲	
	A&G/Specialist Advice (% OPFA)			37.52%	▲	
	A&G/Specialist Advice diversion rate (volume diverted)	✓	4,686	6,302	▼	
	Specialist Advice Diversion rate (%)		22.39%	22.08%	▼	
	Moved or Discharged to PIFU (volume)	✓	3,081	4,548	▲	
	Moved or Discharged to PIFU (% OPA)	✓	1.37%	2.00%	▲	

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). In Aug-23, 28,545 specialist advice requests were raised by NEL GPs (above planned levels), equating to 38% of all first outpatient attendances and 22% diversion rate (requests returned with advice and no onward booking).
- In Aug-23, 4,548 patients were moved or discharged to PIFU, equating to just under 1.4% of all outpatient attendances (Barts Health 1.2%; BHRUT 1.8%; Homerton 5.6%).

Workstream Issues and Risks

- Volume of patients awaiting outpatient appointments and treatment – continued PTL growth
- Difficulty in delivering meaningful and sustained reduction in outpatient follow-up appointments, including ability to measure impact of initiatives due to number of variables and complex nature of and interplay with the waiting list., as well as the risk of perverse / unintended outcomes (across RTT and non-RTT pathways)
- 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 is not be funded in 23/24 and no national incentivisation for A&G/R)
- Impact of ongoing IA 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.,)
- Impact of IA on outpatient transformation initiatives, particularly challenges in being able to drive initiatives forward clinically due to clinician availability as a direct result of IA cover, etc.,
- Volume and deadlines of asks stemming from national programmes e.g. 'Further Faster' and GIRFT' particularly in light of IA, further compounded by lack of national and regional coordination of asks
- ICS finance - no new business cases being recurrently funded (only endorsed) impacting on new investment proposals and which may result in pathway redesign projects not being feasible across NEL

Mitigating Actions and Next Steps

- Ongoing work to support targeted and meaningful reduction in outpatient follow-up activity – incl. development of system level plans, data analysis, modelling and impact assessment across a significant number of specialties. Specific interventions undertaken in T&O incl. BHRUT virtual fracture treatment pathway and Homerton pre-outpatient clinic notes review
- Ongoing development and refinement of 'Waiting Well NEL' website launched in Jul-23
- Ongoing roll-out of 'Advice and Refer' and PIFU across NEL - now considered BAU
- Trust review and learning from NEL insights DNA inequalities analysis
- Continued effort (in context of IA) to roll-out national GIRFT specialty outpatient guidance and 'Further Faster' recommendations by individual Trust outpatient transformation programmes, supported at NEL level – NEL meeting with national 'Further Faster' team held in early November, with ongoing review of data required to understand impact and trends post sign-up to the Further Faster programme
- 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
- Continued progress in work streams for MSK, Women's Health (gynae), ENT, Ophthalmology and Dermatology to develop alternate pathways and maximise community capacity
- Referral optimisation workshop held in September identifying 5 high impact referral optimisation initiatives to be taken forward (incl. support and information for GPs, advice and refer, standardised referral templates and models of triage, and straight to test optimisation) – 2nd workshop planned for early November to include clinicians and Ops

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

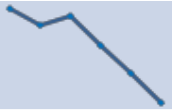
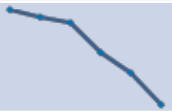
Diagnostics – August 2023

SRO:	Claire Hogg	RAG	AMBER

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

	Metric	Latest Published August-2023									
		Waiting List Performance					Activity (% BAU 19/20)				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend	Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Diagnostics	Magnetic Resonance Imaging (MRI)	✗	85.27%	77.25%	▼		✓	105.76%	121.70%	▼	
	Computed Tomography (CT)	✗	96.76%	81.46%	▼		✓	119.55%	134.70%	▲	
	Non-obstetric Ultrasound (NOUS)	✓	83.18%	85.57%	▼		✓	99.51%	108.09%	▼	
	Colonoscopy	✗	97.03%	89.73%	▼		✗	95.87%	69.72%	▼	
	Flexi Sigmoidoscopy	✗	98.00%	74.69%	▼		✗	55.80%	42.27%	▼	
	Gastroscopy	✗	99.31%	76.36%	▼		✗	90.98%	88.63%	▼	
	Echocardiography	✗	98.40%	97.51%	▼		✗	114.36%	111.52%	▲	

Diagnostics – Aug 2023

SRO:	Claire Hogg	RAG	AMBER

Key Headlines

- In Aug-23, there were 54,627 patients waiting for a diagnostics test in NEL (-1907 Pathways compared to Jul-23) position and the no. of patients waiting >6 weeks (backlog) saw an increase to 10,825 (+1,193 pathways compared to Jul-23) driven by increases at across all three NEL Providers.. Thus giving performance of 80.13% against the DM01 Target of 99%. (National requirement to deliver 95% by 2025).
- Performance - At modality level, NEL achieved one (NOUS) of the seven 2023/24 Op Plan W/L Trajectories in Aug-23 albeit NEL still continues to report the highest volume of patients waiting an imaging investigation in London.
- Barts - DM01 Position deteriorated at Barts Health due to challenges in MRI, NOUS, and Paeds Audiology. The Paeds Audiology position has increased the Trusts overarching W/L and backlog size.
- BHRUT- DM01 performance impacted by the availability of radiologists over the summer, Radiology are tracking the weekly position and are using a range of capacity prioritisation, insourcing & outsourcing responses to mitigate a significant change in DM01 compliance. The overall picture within Radiology remains relatively stable with respect to operational performance and service improvement plan is being developed for Neurophysiology.
- Homerton– DM01 Position improving with compliance across NEL Imaging Modalities soon. Sectra PACS now implemented and a number key dependencies highlighted around additional access to IS and NHS mutual aid. Clinical staffing capacity to deliver activity trajectories, admin and project resources to support recovery at pace and Information sharing and contracts with IS and outside NEL NHS.
- Activity – At modality level, NEL is delivering three MRI (121%) , CT (134%) and NOUS (108%) of the seven 2023/24 Op Plan Activity Trajectories in Aug-23.
- Industrial Action, Staff and patient related sickness are key drivers to NEL monthly DM01 position in Aug-23.
- Provisional Month end data for Sept-23 indicates NEL W/L at 54,473, backlog position at 11,348 and performance of 20.83% It is important to note the impact of the Industrial action (IA), Seasonality, Patient choice and clinic cancellations.

Workstream Issues and Risks

- Barts Paeds Audiology – expecting to be compliant by end of financial year (subject to business case approval and start of communitas service provision).
- Other workstream risks also pertain to the constrained funding envelope accessible to the NEL system, benefits of schemes to increase capacity and improve productivity are not realised at the predicted rate of demand growth, alterations to local agreements, to increase throughput and staff plans for 12 hour day/7 day week working are not realised, deficit in the funding requirement to implement all digital initiatives, workforce initiatives in improving recruitment pipelines, via training academies and other schemes are not realised.
- SBH highlighted possible backlog of echo surveillance cases albeit risk is still being quantified (and should be reported in the waiting list – an internal review is ongoing.
- There is a risk that the outputs of BHRUT's approach to understand their reporting capacity and demand profile would not align with the NEL wide timeline, or generate the expected data to inform the conversation around reporting capacity across the system. There is also a risk to the programme due to the non-recurrent funding arrangements and proposed governance structure(s) will need to be reviewed for priority posts.

Mitigating Actions and Next Steps

- Barts Paeds Audiology contract was agreed though their governance routes at the end of Oct-23 and aim to clear the backlog within six months with oversight from NEL Performance colleagues.
- Other Diagnostics (DM01) issues are being mitigated locally by NEL Acute Providers and NEL ICB Colleagues.
- Mitigations include collaborative capacity, reviewing opportunities to manage patient demand on diagnostic services through enhanced engagement with primary care leaders, patient representatives and GPs, as well as reviewing referrals pathways from within secondary and tertiary care providers.
- Implement proposed adjustment to DM01 reporting, Progress case for single point of access and referral and Confirm future support requirements for outstanding areas of challenge including US, MRI and cardiac services.

Governance

- NEL diagnostics performance risks, delivery and recovery are discussed at the monthly Diagnostics Programme Board attended by NELIC Provider colleagues and
- Imaging, Endoscopy and Echo Networks are well established across NEL with regular meetings held on a weekly basis. There is a move to set up the Physiological Network across NEL.
- NEL Imaging Planning and recovery meeting continues bi-weekly with attendance from all three NEL Acute Providers who also attend the NEL Imaging Programme Board monthly.

Cancer – August 2023

SRO:	Femi Odewale	RAG	AMBER

	Metric	Latest Published August-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Cancer	Waiting List >62 Days (volume)	✓	576	548	▲	
	Faster Diagnosis Standard (%)	✗	77.48%	73.91%	▼	

KEY

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

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▼/▲ deterioration ▼/▲ improvement

Workstream Issues and Risks

- RDC Clinic – issue being managed between Trust and Cancer Alliance relating to workforce – interim solution for mutual aid support by BHRUT. Work underway to recruit on a more permanent basis.
- Industrial strikes had an impact on Barts overarching performance within our system as staff were deployed to support system operational pressures.
- Barts remains in the Tiering stratification (i.e. organisations with a backlog above their fair shares requirement) and bi-weekly meetings with NHSE regional colleagues are on-going.
- Barts have initiated a Drive to 5 backlog plan to reduce its 62d PTL backlog position down to 5%
- The Provider is managing risks around histopathology turnaround times, workforce vacancies, imaging reporting and any cancelled cases from IA; provider BIU preparing for CWT upload changes.
- Clinical review of pathways ongoing with added focus on Skin, ENT and Colorectal tumour sites.

Governance

- NEL ICB Cancer Alliance and Performance team 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 submitted Op Plan Trajectories.

Key Headlines

- NEL posted the strongest cancer performance across all London ICBs in Aug-23, delivering four of the nine cancer waiting time (CWT) constitutional standards for patients.
- The 2 week-wait standard slipped this (92.93%). All systems across London (NEL) struggled to achieve the Target. NEL position performance was above the London aggregate position of (78.82%).
- The no. of patients waiting >62 Days (backlog) saw an increase this month to 548 against a target of 576 in Aug-23. However the 62 Day Urgent Referral standard (59.43%) was not met this month. Challenges in the diagnostic phase (histopathology) of cancer pathways remain a key risk to delivery across NEL, but remedial plans ongoing.
- NEL did not achieve the 28 Day Faster Diagnosis Standard (FDS) (73.91%) in Aug-23 a deterioration when compared to the previous month. Only Homerton achieved > 75% threshold this month and mitigating actions are in place to deliver performance improvements at BHRUT and Barts going forward.
- NEL has made significant progress in reducing the no. of patients waiting > 62-days (backlog) in recent months. As at **22 Oct-23,** NEL had a total of (571 Patients) waiting >62 Days representing 6.9% of the total PTL size of 8,240. (unvalidated); lowest across all London ICB's, below London average (7.8%) and England average of (9.0%).
- Although Barts Health remains in Tier 2 for Cancer, the backlog position which was improving has been impacted by IA with both NEL CA and Barts continuing to provide NHSE region with regular progress updates.
- NHSE letter dated 17/08 has proposed changes to CWT standards from 1 Oct-23. This rationalises the standards into three core measures for the NHS: The 28-day Faster Diagnosis Standard (75%), One headline 62-day referral to treatment standard (85%) and One headline 31-day decision to treat to treatment standard (96%).
- NEL CWT Shadow performance for Aug-23: 28 Day FDS (73.92%), 62 Day Combined (67.10%), 31 Day Combined (96.71%) .

Mitigating Actions and Next Steps

- The NEL Cancer Alliance continues to work with providers targeting key pathways 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 NEL Cancer Alliance also continues to work with providers to implement and strengthen best practice timed pathway and secured additional resource (x 4 Project Managers) to carry out this work across NEL with particular 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 continue to expand, evaluate and sustain these pathways across the region.
- NEL Cancer Alliance continue to fund 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 system improvement.
- 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 – September 2023

SRO:	Paul Gilluley	RAG	RED

	Metric	Latest Published September-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
UEC	Ambulance Handovers ≥ 60 Min (volume)	✗	National Req. ZERO	127	▲	
	12-hour Trolley waits (volume)	✗	National Req. ZERO	1,506	▲	
	Total A&E Attendances (volume)	✓	77,590	77,277	▲	
	A&E 4-Hour Performance All Type (%)	✗	72.65%	68.43%	▼	
	A&E 4-Hour Performance Type 1 (%)	✗	61.82%	60.11%	▼	
	Total A&E Admissions (volume)	N/A	N/A	13,944	▲	
	Percentage of adult G&A beds occupied by patients not meeting the criteria to reside	✗	10.09%	10.41%	▼	

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 Sep-23, 127 ambulance arrivals at NEL emergency departments (EDs) took more than 1-hour to be transferred from London Ambulance Service care (up slightly 21 on previous month). 99% of LAS handovers took place within 60 min (Bart's 99%, BHRUT 99%, Homerton circa 100%). 63% were handed over within 30 mins (Bart's 60%, BHRUT 53%, Homerton 98%) and 26% within 15 min of arrival at ED (Bart's 19%, BHRUT 18%, Homerton 74%), all three measures slightly worsened on the previous month with the volume of handovers over 30 mins most challenged at Barts.
- In Sep-23, 68.43% of all patients were seen within 4-hours of arrival at ED, which was below the trajectory set at 72.65% submitted in the 2023-24 Operating Plan. The position was a deterioration from the previous month and ends a three month trend of improvement. At Trust level BHRUT saw a slight improvement on previous month whilst Bart's and Homerton worsened. 60.11% of Type 1 patients were seen within 4-hours, down from 61.06% in August and missing the trajectory (61.82%) for the month.
- 12 Hour trolley waits (from decision to admit to admission) rose again in September to 1,506 (up from 1,084 in August) and back to levels pre-summer and before the significant reduction in July.
- System winter planning has commenced, with a plan to hold a collaborative event in early October, the planning will also explore how we forecasting improvement in 4 hour performance and Category 2 offloads in Q3 & 4.

Workstream Issues and Risks

- The UEC programme has prioritised 5 key workstreams: Winter planning, Hospital flow including SDEC, Ambulance and SCC, Mental Health in ED and Type 3 Urgent Treatment Centre
- Category 2 offloading for patients remains challenging despite hospital improvement, The system and partners continue to work with London Ambulance Service
- 12 hour waits in ED have increased which has both a quality and potential patient outcome impact, this is a key area of improvement required programme wise, areas to support this are Medically optimised (Discharge ready)), 14 days length of stay continue to be areas where improvement focus will continue with discharges by 11am impacting on flow and length of stays in ED.

Mitigating Actions and Next Steps

- W45 Handover pilot review completed , NEL ambulance and flow optimisation group now established, including ambulance offloads and response, REACH impact, Physician response unit, STEP processes and the development of single clinical assessment model.
- 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 – Quarterly: Q1 ; Monthly: Aug & Sep 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	Monthly reported	**Appointments in General Practice - Aug-23**	✓	**902,577**	**929,151**	▼
		E.T.3 - The number of people discharged by location and discharge pathway per month (Total) - Sep-23	×	**8,923**	**8,101**	▲
		E.T.3a - Hospital discharge pathway activity - pathway 0 - Domestic home or Other place - Sep-23	×	7,401	6,758	▲
		E.T.3b - Hospital discharge pathway activity - pathway 1 - Domestic home or Other place or Hotel (as temp place of residence) - Sep-23	×	1,083	936	▲
		E.T.3c - Hospital discharge pathway activity - pathway 2 - Care home, Designated setting, Hospice, Community rehab setting - Sep-23	×	144	140	▼
		E.T.3d - Hospital discharge pathway activity - pathway 3 – Care Home, Designated setting - Sep-23	×	295	267	▲
		E.T.5 - The number of patients on the virtual ward - Sep-23	×	**367**	**200**	▼
		The number of patients that the virtual ward is able to simultaneously manage - Sep-23	×	459	297	▲
		Virtual ward occupancy - Sep-23	×	79.96%	67.34%	▼
	Quarterly reported	**Learning disability registers and annual health checks delivered by GPs - Q1 23/24**	✓	**7.53%**	**13.39%**	▼
		2-hour Urgent Community Response (UCR) care contacts - Count of 2-hour UCR first care contacts delivered within reporting quarter - Q1 23/24	×	**2,517**	**2,100**	▼
		Percentage of 2-hour standard UCR referrals achieved at the end of the reporting period (National Req. 70%) - Q1 23/24			**79.76%**	▲
		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 - Q1 23/24	×	**20,691**	**34,197**	▲
		Number of CYP (0-17 years) on community waiting lists - Q1 23/24	×	7,502	11,898	▼
		Number of Adults (18+ years) on community waiting lists - Q1 23/24	×	13,189	22,299	▲

- 2 Hour UCR data – due to technical issues with the ELFT submission the Q1 data does not include ELFT delivered care contacts for May.
- Virtual Ward occupancy data source is NHSE Regional Team VW Data Quality Report as issues have been raised with NHS Foundry VW Dashboard data.

Key Headlines

Primary Care

- July data 938,620 booked appointments. On track to meet the operating plan trajectory of 1 million appointments by March 2024, this is a 3% increase of appointments on the previous year, taking population growth into account.
- Face to face appointments have returned to being the most frequently used mode of contact. 65% of appointments are being conducted face-to-face compared to 33% telephone appointments.
- Local workstreams are in being put in place to implement The Primary Care Recovery Plan. 60 practices will transfer over from analogue to digital cloud telephone systems from April 2024 to support demand management including the 8am rush for appointments and provide appropriate patient triage.
- 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. This will help to ensure that all appointments are captured in the data.
- Plans to implement integrated same day access, under the Fuller Programme are being put in place.

Hospital Discharge

- We continue to see good discharge performance across NEL with low numbers of delayed discharges in hospital beds. Across the month 11.55% of beds were occupied by patients that are ready to be discharged, which is a slight improvement on June which saw 11.68% performance. This is lower than the London and England average.

Virtual Wards

- Scoping exercise to capture additional VW capacity already being provided across NEL that is not currently captured through Foundry reporting.
- System wide mapping exercise to understand what digital tools are in use across the provider platforms to avoid unnecessary procurement and reduce costs.
- National funding for VW will come through UEC channels from April 2024.

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.

2 hour UCR

- UCR – Based on the published data: At NEL Level the UCR 2 hours standard has been achieved (85% overall against 70% target). NELFT (86%) and Homerton (95%) against 70% target. Due to technical issues with the ELFT submission the Q1 data does not include ELFT delivered care contacts for months May, this has been raised with ELFT and national team for re-submission.

Community Waiting List

- NEL ICB ranks 10th out of 42 ICBs; a decline from 16th position in April with 21,885 adult referrals above the average of 17,734. NEL ICB ranks 4th out of all the ICBs, a regression from 5th in April with 13,026 child referrals above the average of 5,505. The number of adult referrals across NEL in May 2023 was 21,885 a 33% increase compared to April. This is comprised of; 28% Barts, 27% ELFT, 22% NELFT, and 22% Homerton. The number of child referrals in May 2023 was 13,026 a 12% increase compared to April. This is comprised of 48% NELFT, 23% ELFT, 15% Homerton and 14% Barts.
- Overall for NEL there has been an increase in the number of referrals for children and adults, with significant increases in Barts referrals for children's and adults services. There may be a need to further understand the reporting for Barts. All other providers saw in increase in referrals apart from referrals to Homerton children's services. Significant increases were seen in referrals to Barts adults and children's services compared to April. Further drill down is required as there seems to be inconsistencies in service reporting between April and May, for example there is no reporting of Barts adult audiology service for May but in April there were 1,500 referrals.

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 were uncategorised at the start of the year.
- 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).
- Access and patient satisfaction: despite appointment numbers increasing the 2023 GP Patient survey shows overall that although patient experience overall is improving, patients have the have least positive experience when making an appointment.

Hospital Discharge

- Whilst discharge performance is good relative to other systems, we are have seen high levels of pressure on acute wards. Continuing industrial action has required considerable focus therefore detracting from ongoing improvement work. We have pressures across our care market, particularly for more specialist or complex placements.

- **Virtual Wards**
- NEL on track to deliver target planned for December 2023, however current planned capacity of 588 beds is short of end of year target of 735 beds.
- NEL currently reporting 0% tech enabled as part of VW returns, there are some tech enabled pieces of work e.g. Doccla pilot to be captured. Securing funding for providers to be able to continue providing VW services and security of funding for workforce.

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 is back meeting the 2hr UCR Target.
- NEL is working to start back the UCR referral increase pilot with LAS in time for winter. It was felt that the digital push/pull pilot for 111/999 would need more scoping discussions and development time. NEL continues to meet the 9 clinical matrix standards but more work needs to be done to check consistency across providers and new requirements like self- referrals.
- Falls prevention continues to be a focus area for Enhanced health and care homes delivery and is being picked up alongside a review of UCR delivery. A key area of work has begun to allow Care Homes access to MIDoS services finder tool so that alternative call options is the first route for Care Homes before ED. In addition is work that has progressed with the Urgent Care Plan that is now rolled out across NEL to prevent unnecessary admissions for those who have a care plan.

Community Waiting List

- Although there has been a decrease in the number of referrals waiting over 52 weeks, there are significant increases in demand for up to 18 weeks. With issues with workforce this may compound the issue further and we may see additional waits over 52 weeks in the following months. Barts MSK service has 5,247 referrals waiting up to 12 weeks, we may see longer waits if demand continues. ELFT MSK service also has high volume of referrals with 25 waiting 18-52 weeks. Homerton MSK service is also seeing high volume of referrals with 21 waiting 18-52 weeks.

Mitigating Actions and Next Steps

Primary Care

- Improvements in coding are being incentivised through the Capacity and Access Improvement Plan.
- 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.
- 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.
- The GP Recovery Plan commits to using digital telephony by March 2024 to enable improved queuing systems and call management. Training will provide practices and PCNs with the tools to provide at scale services that can triage and direct patients to the most appropriate appointment and advice.
- Opening Hours An exercise is currently being undertaken with 22% of practices that have stated they are closed for a period of time during core hours, to support them to open to patients during this time in order to fulfil their contractual responsibilities.

Hospital Discharge

- Each Place is working to improve discharge, particularly now in readiness for winter. Key actions include:

-Mobilising additional bedded and domiciliary care capacity funded through the BCF discharge fund
-Ensuring optimal running of our care transfer hubs in each place/hospital site
-Focusing on discharge to assess and home first to support more people to live independently at home, and to reduce pressure on our bed based settings.

Virtual Wards

- Scoping exercise looking at VW capacity and system will look to mitigate for gap in March 2024 target. Tech mapping exercise will increase accurancy of tech enablement reporting to NHSE. Working through funding model so that providers can continues to provide VW services and retain workforce with focus on quality and impact measures.

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 UCR to enable more cases to be pulled into UCR services from LAS. However this will be a manual as we heads into winter. UCR leads and operational teams felt that the digital pathway needs more development and agreement across the system. The winter plan will enable ICB to look at its readiness better for a digital solution with LAS. This scheme will start in September and should see us increase volume into UCR.
- ELFT data issues being picked up with ELFT team to ensure we do not miss trajectory targets as this is dragging down trajectory numbers. Team has been notified to make timely submission for this month onto CSDS.
- Work is underway to better understand the impact of above trajectory performance to deliver 2 hour UCR on the rest of the system / more UEC interface working and sharing has begun.

Community Waiting List

- Waiting List BCYP element - Deep Dive Actions: Major deep dive work has been completed looking at waiting times resulting in more system ownership to deliver against 4 pillars in coming months quickly – 1) Development of Communities of Practice across key problem spots / QI 2) Data Quality Improvements including deep cleansing collectively 3) Agree SOP for SALT across providers and implement expectations 4) Workforce Transformation . Community Collaborative will support delivery and map improvements over time. Workshop in the Autumn being planned already to review BCYP programme. In addition, the next steps actions do now feel more system owned. Waiting times issues have been highlighted across various workstreams and providers as a result of the deep dive and data cleanses. Place Partnerships are more involved in the issues and are aware of the various problems around clearing backlog i.e. workforce including skill mix and increases in service demand. With system ownership work has begun to use the 4 recommendations to get interventions underway.
- Waiting List Overall – Collaborative will continue to have full sight of waitlist data as improvement plan is put into place and is working with BCYP Programme to review the way it works to drive and support change.
- Waiting List Overall - Forward Plan in place to ensure NEL meets trajectories from main providers - Bart's, ELFT, NELFT, Accelerate, Homerton – by Q4 and 52 week target by early Q1 23/24 FY. There is no national target but London has now convened a waiting list meeting for ICBs to have sight early of this. They are using these to flag focus areas ICBs should start to look at. NEL is already focused on these areas.

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.

Hospital Discharge

- Each place based partnership is accountable for discharge via their partnership boards. The operational rhythm for managing discharge is as follows:

-Daily or twice daily discharge hub meetings
-Daily NEL escalation call
-Weekly place based escalation calls
-Fortnightly or Monthly place based discharge groups (sometimes combined with place urgent care groups)
-Fortnightly NEL discharge improvement group

Virtual Wards

- Programme reports in to the UEC Board which provides the governance for delivery and monitoring. NEL Steering group set up to manage operational and clinical delivery and expectations. The Community Collaborative which provided governance for the VW previously continues to monitor delivery/progress via monthly highlight reporting.

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**

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

Community Waiting List

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

Mental Health – August 2023

SRO:	Paul Calaminus	RAG	AMBER

	Metric	Latest Published				
		Aug-23	*Trajectory*	*Actual*	Change from prev. Month	6 Month Trend
Mental Health	IAPT Access (Rate)	✓	*25.54%*	*27.51%*	▲	
	Dementia Diagnosis (Rate)	×	*66.70%*	*60.18%*	▼	
	SMI Physical Health Checks (Performance)	×	*70.00%*	*55.25%*	▼	
	Perinatal (Rate)	×	*8.13%*	*7.98%*	▲	
	CYP Access (Volume)	✓	*22,997*	*23,390*	▲	
	Early Intervention in Psychosis (EIP)	✓	*60.00%*	*71.88%*	▼	
	CYP Eating Disorders Urgent Referral (Performance)	×	*95.00%*	*85.00%*	▼	
	CYP Eating Disorders Routine Referral (Performance)	×	*95.00%*	*93.00%*	▼	
	Community Metal Health Access (Volume)	✓	*21,132*	*23,130*	▲	

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

- There has been a continued improvement in CYP access rates (which is achieving its target) and small improvements in Perinatal and Dementia access rates but there remains a significant gap to target.
- Despite excellent performance in 2022/23, performance in SMI PHC has dipped in June and September 2023 (latest data). This combined with an updated target of 70% from NHSE has meant that the target was missed for Q1 2023/24.
- The Talking Therapies access rate shows a high level of inequality across NEL ranging from 30% to 20%. INEL continues to have higher access rates than ONEL. ICB level performance has improved in August, meeting the trajectory. However, there is a steep climb to achieve the Q4 NEL target access rate at some Places.
- The NEL position compared with other London systems is mixed. Dementia continues to be the lowest within London, however for Talking Therapies access NEL is at the top.

Workstream Issues and Risks

- SMI PHC SDF investment is currently paused pending a financial review, however performance is slipping against the targets and there is a high risk that the national target will not be achieved by Q4 2023/24.
- Perinatal, Dementia and NHS Talking Therapies are all at risk of not achieving targets.

Mitigating Actions and Next Steps

Ongoing work within the Improvement Networks includes changes to service models to improve effectiveness and productivity, and to address health and social inequalities, as well as aligning investment and workforce planning. Examples include:

- **Talking Therapies access** – focus on recruitment, increasing referral rates, and group therapy uptake
- **CYP access** – increasing primary care access, improving digital access by service users, and increase access in schools via Mental Health support teams
- **Dementia Access**: establishing a Dementia Improvement Network to disseminate best practice
- **Perinatal** – increasing capacity through recruitment, and establishing an Improvement Network
- **SMI physical health checks** – SDF investment to improve peer support, secondary care primary care data flows and reach higher risk, under-served people who have not had a health check for over 2 years.

This work will be supported by an expanded and improvement performance reporting framework.

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

29 November 2023

Title of report	Governance update
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 governance developments which cover the following areas: • Integration of the Waltham Forest ICB sub-committee/Health and Care Partnership Board and the Health and Wellbeing Board • Approval of application by NHSE to amend the ICB constitution • Review of the ICB Standing Financial Instructions Further details on each of these developments are contained within the report below.
Action required	The ICB Board is asked to: • Approve the revised Waltham Forest ICB sub-committee terms of reference • Adopt the revised ICB constitution • Approve the updated Governance Handbook here.
Previous reporting	ICB Board and Sub-committees.
Next steps/onward reporting	The Governance Handbook will be further reviewed on an annual basis.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.

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 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 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 Integration of the Waltham Forest ICB sub-committee/Health and Care Partnership Board and the Health and Wellbeing Board

2.1 The Waltham Forest Health and Care Partnership have developed proposals to hold regular integrated meetings of the ICB sub-committee/Health and Care Partnership with the London of Waltham Forest Health and Wellbeing Board (HWB) from December 2023. Partners from the ICB and London Borough of Waltham Forest have been working to develop the arrangements. A closer alignment of the HWB and the ICB sub-committee/Health and Care Partnership 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.

3.0 ICB constitution

3.1 At its last meeting, the ICB Board approved the proposal to submit an application to NHS England (NHSE) to amend the ICB constitution to increase the number of Non-Executive Members on the Board from three to five. The application was approved by NHSE on 9 November 2023.

3.2 The Board is asked to adopt the revised constitution.

4.0 Standing Financial Instructions

4.1 The Chief Finance and Performance Officer has reviewed the ICB's Standing Financial Instructions and confirmed that no amendments are required.

5.0 Recommendations

5.1 The Board is asked to:

- Approve the revised Waltham Forest ICB sub-committee terms of reference;
- Adopt the revised ICB constitution;
- Approve the updated Governance Handbook.

WALTHAM FOREST

PLACE-BASED PARTNERSHIP

TERMS OF REFERENCE

Contents

INTRODUCTION

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

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

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

    (c) London Borough of Waltham Forest ('**LBWF**')

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

    (e) Healthwatch Waltham Forest ('**Healthwatch**')

    (f) Voluntary sector nominated representative

    (g) Waltham Forest GP Federation Network ('**FedNet**')

    (h) Waltham Forest's Primary Care Networks ('**PCNs**')

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

3. These terms of reference for the PBP incorporate:

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

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

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

        - The Waltham Forest Health and Wellbeing Board (the '**HWB**'), which is a committee of LBWF established in accordance with section 194 of the Health and Social Care Act 2012. The terms of reference for the HWB need to be read as part of the LBWF's Constitution and the version contained in the constitution takes precedence.

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

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

6. Similarly, the HWB is a committee established by LBWF in accordance with section 194 of the Health and Social Care Act 2012, to exercise functions under the Local Government and Public Involvement in Health Act 2007 and other functions which have been delegated to it by LBWF.

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

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

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

North East London Health & Care Partnership

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

Status of the Partnership Board	1. The Partnership Board is a non-statutory partnership forum, which brings together representatives from across Place, who have the necessary authority from the partner organisation they represent to consider strategic policy matters and oversee joint programmes of work relevant to Place. 2. Where applicable, the Partnership Board may also make recommendations on matters a partner organisation asks the Partnership Board to consider on its behalf.
Geographical coverage	3. The geographical area covered will be Place, which for the purpose of these Terms of Reference is the area which is coterminous with the administrative boundaries of the LBWF.
Aim of the Partnership Board	4. The Partnership Board has the following aim: *"Our aim is for the population of Waltham Forest to have healthier lives by enabling them to start well, stay well, and age well, supporting individuals to the end of their lives. We will do this by working together, as partner, community organisations and with our residents to improve health outcomes and reduce health inequality."*
Role of the Partnership Board	5. The Partnership Board is the formal oversight, challenge and escalation forum for the management and delivery of the Waltham Forest integrated care strategy. It has strategic oversight of the implementation of the care transformation work streams involving the ICB, LBWF, Barts, NELFT, representatives from primary care and the voluntary sector and the local community. 6. The purpose of the Partnership Board is as follows: (a) To improve the health and wellbeing of the residents of Waltham Forest. (b) To hold executive responsibility for borough planning and delivery of community development and integrated care provision. (c) To hold executive responsibility for the delivery of agreed transformation programmes. (d) To promote integration between community health services, primary care services and social care services. (e) To involve, engage and co-produce with Waltham Forest residents.

(f) To deliver through population-level health management approaches, using data insight and intelligence to influence priorities.

(g) To align organisational priorities and agendas.

(h) To escalate and address local risks and issues.

(i) To ensure the local community is engaged in system transformation that leads to impactful outcomes for residents.

7. The Partnership Board has the following core responsibilities:

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

- the Integrated Care Strategy produced by the NEL Integrated Care Partnership ('**ICP**');
- the 'Joint Forward Plan' prepared by the ICB and its NHS Trust and Foundation Trust partners;
- the joint local health and wellbeing strategy produced by the Waltham Forest Health and Wellbeing Board ('**HWB**'), together with the needs assessment for the area;

(b) the Place Mutual Accountability Framework.[2]To develop the Place Based Partnership Plan for Waltham Forest ('**PBP Plan'**), which shall be:

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

(c) As part of the development of the PBP Plan, to develop the Place objectives and priorities and an associated outcomes

[2] The Place Mutual Accountability Framework describes what NHS North East London ICB asks the seven Place ICB Subcommittees and wider Place Based Partnerships to have responsibility for and, in turn, what the Place Based Partnerships can expect the ICB to achieve for them. The framework needs to be read alongside the equivalent document that focuses on the role of the provider collaboratives which operate across the ICS area. The current versions of these frameworks are published in the ICB's Governance Handbook.

framework for Place. A summary of these priorities and objectives can be found here.

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

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

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

- understanding of quality issues at place level, and the objectives and priorities needed to improve the quality of care for local people.
- timely insight into quality concerns/issues that need to be addressed, responded to and escalated within each partner organisation through appropriate governance structures or individuals, or to the SQG.
- positive assurance that risks and issues have been effectively addressed.
- confidence about maintaining and continually improving both the equity, delivery and quality of their respective services, and the health and care system as a whole across Place.

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

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

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

- improve outcomes in population health and healthcare;
- tackle inequalities in outcomes, experience and access;

- enhance productivity and value for money;
- help the NHS support broader social and economic development.

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

8. The **priority workstreams** are below and will be reviewed annually by the Partnership Board:

(a) **Wellness and wellbeing** programmes to prevent illness and promote self-care.

(b) **Care Closer to Home** programmes to ensure care is planned and admissions to hospital are avoided, including the development of the Centre of Excellence.

(c) **Home First** programme to ensure timely, safe hospital discharge.

(d) Establishing a **Centre of Excellence** to take forward the principles of Home First and Care Closer to Home.

(e) **Long Term Conditions:** reduce the prevalence and impact of long-term conditions on residents' lives.

(f) **Mental Health:** To improve the mental health and well-being of the people of Waltham Forest and access to support and care.

(g) **Children's Health:** Develop and improve children's services to ensure children have the best start in life.

(h) To deliver system **Urgent and Emergency Care** transformation programmes as they relate to Waltham Forest.

(i) To support the delivery of Provider Alliance led **Mental Health and Learning Disability** transformation programmes at Place.

(j) To deliver **End of Life** service transformation.

(k) To reduce health inequality by improving access to healthcare for people experiencing **homelessness** in Waltham Forest.

Statutory decision-making

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

	6. However, ordinarily, in accordance with their specific governance arrangements set out in Section 2, a decision made by a committee or other structure (for example a decision taken by the Place ICB Sub-Committee on behalf of the ICB) will be with Partnership Board members in attendance and, where appropriate, contributing to the discussion. This is, however, subject to any specific legal restrictions applying to the functions of a partner organisation and subject to conflict of interest management.
Making recommendations	7. Where appropriate in light of the expertise of the Partnership Board, the Partnership Board may also be asked to consider matters and make recommendations to a partner organisation or a governance structure set out in Section 2, in order to inform their decision-making. 8. Note that where the Partnership Board is asked to consider matters on behalf of a partner organisation, that organisation will remain responsible for the exercise of its statutory functions and nothing that the Partnership Board does shall restrict or undermine that responsibility. However, when considering and making recommendations in relation to such functions, the Partnership Board will ensure that it has regard to the statutory duties which apply to the partner organisation. 9. Where a partner organisation needs to take a decision related to a statutory function, it shall do so in accordance with its terms of reference set out in Section 2, or the other applicable governance arrangements which the partner organisation has established in relation to that function.
Collaborative working	10. The Partnership Board and any governance structure set out in Section 2 shall work together collaboratively. It may also work with other governance structures established by the partner organisations or wider partners within the ICS. This may include, where appropriate, aligning meetings or establishing joint working groups. 11. The Partnership Board may establish programmes, working groups or task and finish groups, to inform its work. Any working group established by the Partnership Board will report directly to it and shall operate in accordance with terms of reference which have been approved by the Partnership Board. *Collaboration with the HWB* 12. The Partnership Board will work in close partnership with the HWB and shall ensure that the PBP Plan is appropriately aligned with the joint local health and wellbeing strategy produced by the HWB and the associated needs assessments, as well as the overarching Integrated Care Strategy produced by the ICP. 13. The Partnership Board is closely aligned with the HWB through similarity in membership and items to be considered at its meetings. As such, meetings of the HWB will generally be combined with meetings of the Partnership Board and Place ICB Sub-Committee.

Safeguarding collaboration

14. The Partnership Board will also work in close partnership with the Waltham Forest Safeguarding Children Partnership and the Safeguarding Adults Board for Waltham Forest.

Chairing and executive lead arrangements

15. The Partnership Board will be chaired jointly by the Chief Executive of Whipps Cross Hospital and LBWF's Strategic Director of People ('**the Co-Chairs'**). It is expected that the Co-Chairs will chair meetings jointly and resolve issues between them but, where only one Co-Chair is present, that person will assume the joint responsibilities of the Co-Chairs.

16. If for any reason the Co-Chairs are absent for some or all of a meeting, the members shall together select a person to chair the meeting.

17. The Co-Chairs will also be the joint Place Executive Leads.

18. Where the meeting is held in tandem with the HWB in accordance with paragraphs 13 and 25, the Co-Chairs will agree the agenda with the Chair of the HWB. It is intended that HWB agenda items will be considered first at such aligned meetings under the chairship of the HWB. The Co-Chairs will then chair the remainder of the meeting.

Membership

19. There will be a total of 22 members of the Partnership Board, as follows:

Joint roles

(a) Delivery Director for Waltham Forest (ICB/NELFT)

(b) Integrated Care Programme Director (NELFT/ICB)

(c) Assistant Director Integrated Commissioning

ICB

(d) Clinical Care Director for Waltham Forest

(e) Director of Finance or their nominated representative

(f) Head of Primary Care, Waltham Forest

LBWF

(g) Strategic Director of People (**Co-Chair**)

(h) Portfolio Lead Member for Health and Wellbeing

(i) Director Adult Care and Quality Standards

(j) Corporate Director Children's Social Care

	(k) Director of Public Health (l) Director of Housing *Barts* (m) Chief Executive, Whipps Cross Hospital (**Co-Chair**) (n) Medical Director, Whipps Cross Hospital (o) Whipps Cross Redevelopment Director *NELFT* (p) Executive Director Strategy and Partnerships (q) Integrated Care Director *Primary Care* (r) Place Based Partnership Primary Care Development Clinical Lead) (s) Medical Director, FedNet (t) 2 x PCN Directors *Others* (u) Chief Executive, Healthwatch (v) Voluntary sector nominated representative 20. With the permission of the Co-Chairs of the Partnership Board, the members, set out above, may nominate a deputy to attend a meeting of the Partnership Board that they are unable to attend.
Participants	21. The Partnership Board may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This shall include other colleagues from the partner organisations or across the ICS, professional advisors or others as appropriate at the discretion of the Co-Chairs.
Meetings	22. The Partnership Board will operate in accordance with the evolving NEL ICS governance framework, including any policies, procedures and joint-working protocols that have been agreed by the partner organisations, except as otherwise provided below: *Scheduling meetings* 23. The Partnership Board will normally meet monthly, on the first Monday of each month.

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

25. The Partnership Board may also hold its meetings in tandem with the HWB which, in accordance with its terms of reference, meets at least four times per year.

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

27. Changes to meeting dates or calling of additional meetings will be convened as required in negotiation with the Co-Chairs.

Quoracy

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

    (a) Two of the members from the ICB;

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

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

    (d) One primary care member.

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

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

Papers and notice

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

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

Virtual attendance

33. It is for the Co-Chairs to decide whether or not the Partnership Board will meet virtually by means of telephone, video or other electronic

	means. Where a meeting is not held virtually, the Co-Chairs may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes. *Admission of the public* 34. Where the Partnership Board meets jointly with the Place ICB Committee in accordance with paragraph 26, its meetings shall be held in accordance with the Place ICB Committee's terms of reference in Section 2. Otherwise, whether a meeting of the Partnership Board is to be held in public or private is a matter for the Co-Chairs. *Recordings of meetings* 35. Except with the permission of the Co-Chairs, no person admitted to a meeting of the Partnership Board shall be permitted to record the proceedings in any manner whatsoever, other than in writing. *Minutes* 36. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the Partnership Board together with the action log, as soon as practicable after the meeting having taken place. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Co-Chairs. 37. Where it would promote efficient administration, meeting minutes, action logs and any work plan, may be combined with those of the Place ICB Sub-Committee and/or other place governance structures in Section 2. *Governance support* 38. Governance support will be provided to the Partnership Board by the ICB's governance team. *Confidential information* 39. Where confidential information is presented to the Partnership Board, all those present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.
Decision-making	40. The Partnership Board is the primary forum within the PBP for bringing a wide range of partners across Place together for the purposes of determining and taking forward matters relating to the improvement of health, wellbeing and equity across the borough. It brings together representatives from across Place, who have the necessary authority from the partner organisation they represent to

	consider strategic policy matters and oversee joint programmes of work relevant to Place. 41. The Partnership Board does not hold delegated functions from the partner organisations, but each member shall have appropriate delegated responsibility from the partner organisation they represent to make decisions for their organisation on matters within the Partnership Board's remit or, at least, will have sufficient responsibility and be ready to move programmes of work forwards by holding discussions in their own organisation and escalating matters of importance. 42. In the event that the Partnership Board is unable to agree a consensus position on a matter it is considering, this will not prevent any or all of the statutory committees/sub-committees in Section 2 taking any applicable decisions they are required to take. To the extent permitted by their individual terms of reference, statutory committees may utilise voting on matters they are required to take decisions on.
Conflicts of Interest	43. Conflicts of interests will be managed in accordance with relevant policies, procedures and joint protocols developed by the ICS, which shall be consistent with partner organisations' respective statutory duties and applicable national guidance.
Accountability and Reporting	44. The Partnership Board shall comply with any reporting requirements that are specifically required by a partner organisation for the purposes of its constitutional or other internal governance arrangements. The Partnership Board will also report to the ICP. 45. Members of the Partnership Board shall disseminate information back to their respective organisations as appropriate, and feedback to the group as needed. 46.
Monitoring Effectiveness and Compliance with Terms of Reference	47. The Partnership Board will carry out an annual review of its effectiveness and provide an annual report to the ICP and to the partner organisations. This report will outline and evaluate the Partnership Board's work in discharging its responsibilities, delivering its objectives and complying with its terms of reference. As part of this, the Partnership Board will review its terms of reference and agree any changes it considers necessary.

Section 2 (Part A)

WALTHAM FOREST HEALTH AND WELLBEING BOARD[3]

Statement of intent:
The purpose of the Health and Wellbeing Board is to improve the health and well-being of Waltham Forest residents. The Board does this by helping to shape the strategic direction of its multi-agency partnership and by proactively tackling the barriers and challenges to delivering progress on its evidence-based 'wicked' priority issues.

The board is aligned with the Waltham Forest Health and Care Partnership Board ('the partnership') through similarity of membership and items to be considered. As such, board meetings will be combined with partnership meetings.

1. Name

1.1 The Board will be known as the Waltham Forest Health and Wellbeing Board ('the Board').

2. Membership

2.1 Board members are appointed by the Council.. Voting membership is as follows:

- **Chair (see below, 5.1)**
- **Strategic Director, People, LBWF**
- **Elected member – Portfolio Lead, Adults**
- **Elected member – Portfolio Lead, Children and Young People**
- **Elected member – Portfolio Lead, Health and Wellbeing**
- **Director of Public Health**
- **At least two representatives from the North East London Integrated Care Board (NEL ICB) representing the place and the system levels respectively[4]**
- **Representative, Healthwatch Waltham Forest**
- **Representative, Barts NHS Trust**
- **Representative, NELFT**

2.2 Other members may be appointed by the Council after consultation with the Board. Additional members should only be appointed where it is necessary for them to be a voting member and their attendance will be

[3] These Terms of Reference for the Health and Wellbeing Board are included here for ease of reference, but are formally incorporated into LBWF's Constitution and form part of it.
[4] The representatives from NEL ICB are Chief Participation and Place Officer, Delivery Director and Clinical Care Director

required at all meetings. Otherwise, an invitation to attend as a non-voting member should be extended for as long as is necessary.

2.3 Whenever there is a newly nominated appointee, their name, title and contact details must be provided to Democratic Services ten days before either the Annual General Meeting of the Council or before an ordinary Council meeting.

2.4 Members are to provide a named Board deputy who they will brief to attend for any Board meetings that they are unable to.

2.5 Members are expected to adhere to the Waltham Forest Strategic Partnership Boards and Subgroups: Principles for members.

2.6 Officers who are members of the health and well-being board and who are entitled to vote at the board meetings will be subject to the Council's Councillors' code of conduct, as such officers will (where they are able to vote) be regarded as co-opted members.

3. Legal Status

3.1 The Health and Wellbeing Board is a committee of the Council and will adhere to the Constitutional requirements of the Council affecting committees, unless alternative provision is made within these terms of reference or the law.

4. Voting Rights and Quorum

4.1 The quorum shall be one third of the membership eligible to vote or the nearest whole number above one third, with a minimum of three. This must include, at minimum, a representative of the London Borough of Waltham Forest Council and a representative of the NEL ICB.

5. Chair and Vice Chair

5.1 The Chair of the Board shall be the Leader of the Council or their nominated representative who may be appointed from within the standing membership or as an addition to it. The Vice-Chair of the Board shall be an ICB sub-committee representative from the Waltham Forest Health and Care Partnership.

6. Frequency of meetings

6.1 The Board shall schedule meetings at least four times a year.

6.2 As set out at the start of these terms of reference, the board is aligned with the Waltham Forest Health and Care Partnership Board. Meetings will coincide with the partnership in order to consider items falling within the statutory responsibility for the Board.

6.3 At meetings which coincide, the Board will consider those items for which it has responsibility and will be chaired by the Chair of the Board. The meeting will then transition to become a Partnership meeting chaired by the Chair of the Partnership.

6.4 In circumstances where an urgent decision is required by the Board outside of the scheduled meetings, an urgent meeting of the Board will be arranged to coincide with an existing meeting of the partnership in order that the urgent item may be considered.

7. Delegation of Powers

7.1 The Board may establish sub committees to discharge any functions of the Board or to advise the Board in respect of its functions.

8. Functions of the Board

8.1 To exercise the functions of a local authority and its Integrated Care Board under section 26 of the Health and Care Act 2022 and sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007, relating to joint strategic needs assessments, and the joint local health and wellbeing strategy.

8.2 To exercise the statutory functions of a Health and Wellbeing Board in relation to the carrying out and publication of pharmaceutical needs assessments.

8.3 To exercise the statutory functions of a Health and Wellbeing Board in relation to the agreement and monitoring of Better Care Fund plans.

8.3 To encourage creative, professional, integrated partnership working between health and social care services as well as other related agencies and stakeholders.

8.4 To receive and comment on North East London Integrated Care Board forward plans, annual reports, and performance assessments.

8.5 To exercise any other Council functions, which the Council has determined should be exercised by the Board on its behalf, in accordance with section 196(2) of the Health and Social Care Act 2012 including:

- Overseeing the development of local commissioning plans and, where necessary, initiating discussions with the NHS Commissioning Board (NHS England) if an agreed concern exists.
- Leading cultural and behavioural change to support a joint approach to meeting local need.
- Holding all partners to account for their role in the delivery of joint commissioning and overall stewardship of the health and wellbeing outcomes for residents.

8.6 To periodically review the Board's terms of reference.

Section 2 (Part B)
Terms of reference for the Waltham Forest Sub-Committee of the North East London Integrated Care Board

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

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

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

    (a) The Joint Forward Plan;

    (b) The Joint Capital Resource Use Plan;

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

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

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

    (f) The PBP Plan.

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

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

    (a) Improve outcomes in population health and healthcare;

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

    (c) Enhance productivity and value for money;

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

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

Key duties relating to the exercise of the Delegated Functions

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

16. The Sub-Committee must have particular regard to the statutory obligations that the ICB is subject to, including, but not limited to, the statutory duties set out in the 2006 Act and listed in the Constitution. In particular, the Place ICB Sub-Committee will also have due regard to the

public sector equality duty under section 149 of the Equality Act 2010.

Collaborative working

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

Collaboratives

18. In particular, in addition to an expectation that the Place ICB Sub-Committee, HWB and Partnership Board shall collaborate with each other as part of the PBP, the Place ICB Sub-Committee will, as appropriate, work with the following provider collaborative governance structures within the area of the ICS:

    (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.

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

Health & Wellbeing Board and Safeguarding

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

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

	21. The Place ICB Sub-Committee does not have the authority to delegate any functions delegated to it by the ICB. However, the Place ICB Sub-Committee may establish working groups or task and finish groups. These do not have any decision-making powers but may inform the work of the Place ICB Sub-Committee and the PBP. Such groups must operate under the ICB's procedures and policies and have due regard to the statutory duties which apply to the ICB.
Chairing and executive lead arrangements	22. The Place ICB Sub-Committee will be chaired jointly by the Chief Executive of Whipps Cross Hospital and LBWF's Strategic Director of People ('**the Co-Chairs'**), who are appointed on account of their specific knowledge, skills and experiences making them suitable to chair the Sub-Committee. It is expected that the Co-Chairs will chair meetings jointly and resolve issues between them but, where only one Co-Chair is present, that person will assume the joint responsibilities of the Co-Chairs. 23. The Co-Chairs will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference. 24. If one of the Co-Chairs has a conflict of interest then their Co-Chair or, if necessary, or another member of the Sub-Committee will be responsible for deciding the appropriate course of action. 25. The Co-Chairs will also be the joint Place Executive Leads.
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: (d) The ICB (e) Barts (f) NELFT (g) LBWF (h) Healthwatch (i) Voluntary sector nominated representative (j) FedNet

(k) PCNs

29. There will be a total of 10 members of the Place ICB Sub-Committee, as follows:

Joint roles

(a) Delivery Director for Waltham Forest (ICB/NELFT)

ICB

(b) Clinical Care Director for Waltham Forest

(c) Director of Finance or their nominated representative

(d) Chief Participation and Place Officer

LBWF

(e) Strategic Director of People (**Co-Chair**)

(f) Portfolio Lead Member for Health and Wellbeing

(g) Director of Public Health

Barts

(h) Chief Executive, Whipps Cross Hospital (**Co-Chair**)

NELFT

(i) Executive Director Strategy and Partnerships

Primary Care

(j) Clinical Lead for Primary Care

(k) Primary Care Network Director

Others

(l) Chief Executive, Healthwatch

(m) Voluntary sector nominated representative

30. With the permission of the Co-Chairs 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 Co-Chairs 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 Co-Chairs may invite relevant staff to the meeting as necessary in accordance with the business of the Sub-Committee. 33. Meetings of the Sub-Committee may also be attended by the following for all or part of a meeting as and when appropriate: (a) Any members or participants of the Partnership Board (i.e. in Section 1). 34. The Co-Chairs 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	35. 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. 36. The Co-Chairs will be invited to attend the Finance Performance and Investment Committee where the Committee is considering any issue relating to the resources allocated in relation to the Delegated Functions.
Meetings, Quoracy and Decisions	37. 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* 38. 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 Co-Chairs. 39. The Place ICB Sub-Committee will usually hold its meetings together with the Partnership Board and may hold meetings in tandem with the HWB, 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 Co-Chairs, it is expected that such circumstances would be rare. 40. The Place ICB Sub-Committee acknowledges that the Partnership Board may convene its own more regular meetings, for instance where agenda items do not require a statutory decision of the Place ICB Sub-Committee.

41. The Board, Chair of the ICB or Chief Executive may ask the Sub-Committee to convene further meetings to discuss particular issues on which they want the Sub-Committee's advice.

Quoracy

42. The quoracy for the Place ICB Sub-Committee will be six and must include the following of which one must be a care or clinical professional:

    (a) Two of the members from the ICB;

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

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

    (d) One primary care member.

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

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

Voting

45. 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 Co-Chairs 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.

46. Where there is a split vote, with no clear majority, the Co-Chairs will share one casting vote. In the rare circumstances, that the Co-Chairs are unable to agree, the matter shall be referred to the PH&I Committee for determination.

Papers and notice

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

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

Virtual attendance

49. It is for the Co-Chairs 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 Co-Chairs 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

50. Meetings at which public functions of the ICB are exercised will usually be open to the public, unless the Co-Chairs determine, 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.

51. The Co-Chairs 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.

52. A person may be invited by the Co-Chairs 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.

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

54. 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

55. Except with the permission of the Co-Chairs, 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

56. 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

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

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

Legal or professional advice

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

Governance support

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

Conflicts of Interest

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

Behaviours and Conduct

62. 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;

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

Disputes

64. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the Place ICB Sub-Committee 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

65. Where any decision before the Place ICB Sub-Committee is 'novel, contentious or repercussive' across the ICB area and/or is a decision which would have an impact across the ICB area, then the Place ICB

Sub-Committee shall give due consideration to whether the decision should be referred to the PH&I Committee.

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

    (a) The Co-Chairs 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.

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

68. In addition to the Place ICB Sub-Committee's ability to refer a matter to the PH&I Committee as set out in paragraph 65:

    (a) The PH&I Committee, or its Chair and Deputy Chair (acting together), may determine that any decision falling with paragraph 65 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

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

70. The Place ICB Sub-Committee will report to:

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

    And will report matters of relevance to the following:

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

	(c) **Quality, Safety and Improvement ('QSI') Committee.** Reports will be made to the QSI Committee in respect of matters which are relevant to that Committee and in relation to the exercise of the quality functions set out here. 71. In the event that the Chair of the ICB, its Chief Executive, the Board of the ICB or the PH&I Committee requests information from the Place ICB Sub-Committee, the Place ICB Sub-Committee will ensure that it responds promptly to such a request. *Shared learning and raising concerns* 72. Where the Place ICB Sub-Committee considers an issue, or its learning from or experience of a matter, to be of importance or value to the North East London health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the ICB for onward referral to the PH&I Committee, the Chair or Chief Executive of the ICB, the Board, the Integrated Care Partnership or to one or more of ICB's committees or subcommittees, as appropriate.
Review	73. The Place ICB Sub-Committee will review its effectiveness at least annually.
	74. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval: 29 November 2023 (Initial version by ICB Board on 1 July 2022)

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 Partnership Board on behalf of the ICB, to develop the PBP Plan including the Place objectives and priorities and a Place outcomes framework.

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

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

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

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

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

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

Market management, planning and delivery

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

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

2. Approving commissioning policies 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 Place Commissioning Functions being exercised at Place.

Finance

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

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

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

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

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

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

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

7. Review performance of the contracts within Place, 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 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.

Annex 2 – Membership Table

NHS
North East London
Integrated Care Board

Name	Role	Organisation	WF HWBB	WF ICB Sub Committee	WF Place Based Partnership Board
Cllr Naheed Asghar	Portfolio Lead Member for Health and Wellbeing	LBWF	X	x	x
Heather Flinders	Strategic Director, People	LBWF	X	x	x
Cllr Louise Mitchell	Portfolio Lead, Adults	LBWF	X		
Cllr Kizzy Gardiner	Portfolio Lead, Children and Young People	LBWF	X		
Joe McDonnell	Director of Public Health	LBWF	X	x	x
Dianne Barham	Chief Executive, Healthwatch Waltham Forest	Healthwatch WF	X	x	x
Amanjit Jhund	CEO of Whipps Cross University Hospital	Barts NHS Trust	X	x	x
Sue Boon	WF Director of Delivery	NEL ICB	X	x	x
Ken Aswani	Clinical Lead	NEL ICB	X	x	x
Selina Douglas	Executive Director Strategy and Partnerships	NELFT		x	x
Philomena Arthur	Integrated care Director	NELFT	x		x
Daniel Phelps	Director of children's social care	LBWF			x
Darren McAughtrie	Director of Adult Social care	LBWF			x
Pat Smith	Integrated care Programme Director	NEL ICB/NELFT			x
Vanessa Morris	CEX	Mind (C and H, WF)		x	x
Sunil Thakker	Director of Finance	NEL ICB		x	x
Janakan Crofton	Clinical Lead Primary Care	NEL ICB		x	x
Joe Garrod	Director of Housing	LBWF		x	x
Anna Saunders	Assistant Director Integrated Commissioning	NELICB/LBWF			x
Alastair Finney	Whipps Cross Development Director	Bart NHS Trust			x
Asad Ashraf	PCN Director	E4 PCN			x
Naheed Khanlodhi	PCN Director	Walthamstow West PCN		x	x
Sheraz Younas	Medical Director	WF GP FedNet			x
Oluremi Odejinmi	Medical Director Whipps Cross	Barts NHS Trust		x	x
Charlotte Pomery	Chief Officer Participation and Place	NEL ICB	X	X	X

North East London
Integrated Care Board

NHS North East London ICB board

29 November 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 proposed the development of an assurance map which would provide an overall picture of the whole organisation and would help to inform discussions on risk.
Action required	To consider, note and propose any changes to the risk appetite of 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 December. • Board to receive updated BAF in January 2024
Conflicts of interest	No conflicts of interest have been identified in relation to this report.

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

2.0 Risk appetite

2.1 Risk appetite levels had been identified for each risk in line with the grading on the final page of the attached Board Assurance Framework. The board are asked to review the

current risk appetite levels for each of the BAF risks which are all currently graded as cautious.

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 audit and risk committee received a risk management update at its meeting on 18 October which included the corporate risk register and the BAF, the following comments were noted:

- Proposed an assurance map which would provide an overall picture of the whole organisation and would help to inform the discussions on risk.
- Suggested the need for some of the risk ratings and targets on the corporate risk register to be more realistic.
- Recognised the need for a risk appetite review with the board.
- Review links between ICB BAF and BAF of our providers.

4.3 At a recent meeting of the quality, safety and improvement committee (QSIC) discussion ensued on the Chief Nursing Officer's risk register vs the QSIC risk register and how system risks are included on this. The governance team are developing proposals to deliver a revised risk register for each committee to ensure that there is cross reference between chief officer risk registers.

4.4 The population health and integration committee (PHIC) recently reviewed the BAF given the purpose and remit of the committee, and the strategic overview the committee has across the system. Members of the committee were asked to consider each risk and think through a number of questions. The following comments and changes were proposed:

- The target dates should be more dynamic due to the longer-term strategic risks on the BAF which would support momentum to deliver solutions to mitigate the risks, therefore providing assurance to the board.
- No risk should sit in isolation in terms of committee oversight.
- The PHIC recommended that the responsibility for risk number CSTO01 be moved from the ICP committee to PHIC. "There is a risk that ICS partners do not work together and with local people, communities and stakeholders in collaborative and strengths-spaced ways and so cannot delivery on our ICS purpose, aims and priorities and will have limited impact on improving the health and wellbeing of local people and reduce inequalities."

4.5 Given the feedback and suggestions above, the ICB risk management policy and strategy will be reviewed and updated accordingly.

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 review the ICB risk management strategy and policy in light of comments from ICB committees.

6.2 Any proposed changes to risk appetite will be included in the next report to board.

6.3 Regular reviews of the corporate risk register will continue along with meetings 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.

7.0 Attachments

7.1 Board Assurance Framework

Board Assurance Framework November 2023 – Dashboard

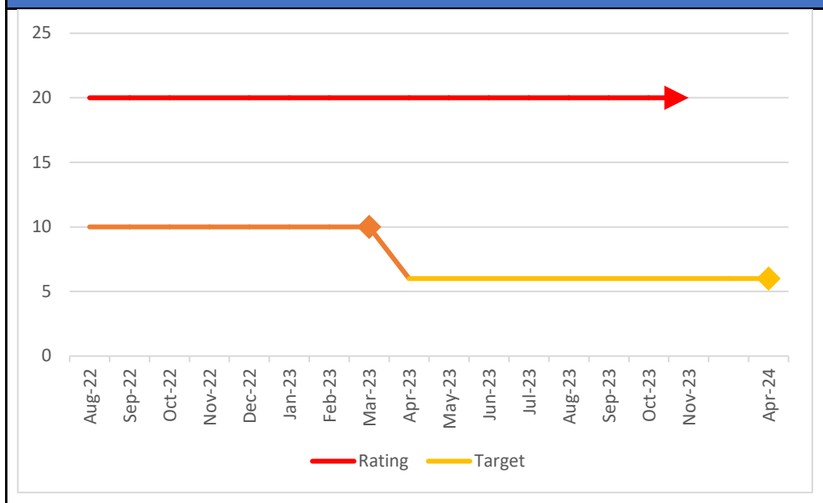
North East London Integrated Care Board

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	Aug/ Sep	Oct/ Nov			
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	Population Health and Integration Committee	16 NEW RISK TO BAF	12	12	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	20	15	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	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	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	20	20	6	**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	10	10	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	8

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	Aug/ Sep	Oct/ Nov			
	There is a risk that if ICS partners do not share mutual accountability for the delivery of current and future operating plans and constitutional standards, this could result in clinical variation and negatively impact on quality and performance improvement. In turn, this could lead to poorer experience and outcomes for service users.	Henry Black	Finance, Performance and Investment Committee	N/A	N/A	15 NEW RISK TO BAF	15 ↔	15 ↔	15 ↔	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	9
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 ↔	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 ↓	12 ↔	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 ↔	15 ↔	12 ↓	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 ↔	16 ↔	16 ↔	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	3

Board Assurance Framework – November 2023

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)	November 2023	Work is continuing across the system to address the financial risk held by both local authorities and the ICB across north east London. The NHS element is currently detailed in the operational plan and more lately in the Financial Recovery Plan. Since the last update a system Recovery Director has been appointed and a Financial Recovery Board and an associated governance structure has been operationalised. Delivery of efficiency programmes continue to be led by individual organisations including an internal ICB transformation programme. Progress and delivery will continue to be monitored across the system through the Financial Recovery Board and discussed at recovery forums including CFO meetings. The risk requires transformational resource in order to deliver across the ICS and to attempt to reduce the risk and financial fragility of all partners.

Controls and assurances
Monthly system level reporting and ongoing review of specific financial risks and opportunities. Reports presented to the Executive Committee bi-monthly, the Financial Recovery Board 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.
ICS Recovery Director appointed and Financial Recovery Board in place.

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
ICB (led by CSTO) working to identify savings and development of recovery plans.	31.03.24
Review of investments being undertaken.	31.03.24
Efficiency programmes are being led by individual organisations, with some cross organisational transformation programmes.	31.03.24
Detailed analysis of the drivers of the deficit for the NHS and local authorities at a place level	31.03.24
Session to share detail of financial risk held by local authorities and the ICB	31.03.24

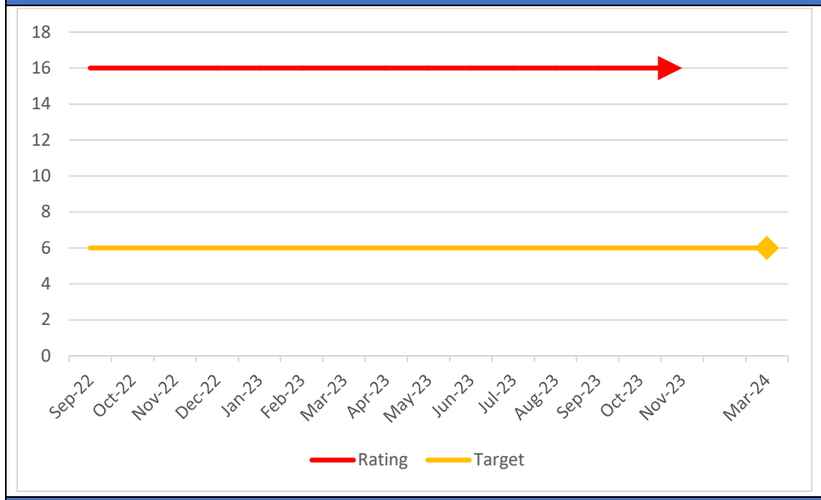
ICS Aim	To improve outcomes in population health and healthcare							Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO01
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Johanna Moss
	✓		✓		✓		✓			Responsible committee	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 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	April 2024	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)	November 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
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.	Existing
Seeking a development partner who will work with key leadership groups across the ICS to help us agree what working together more effectively and closely means in NEL. Procurement for this partner is due to commence in September.	October 2023

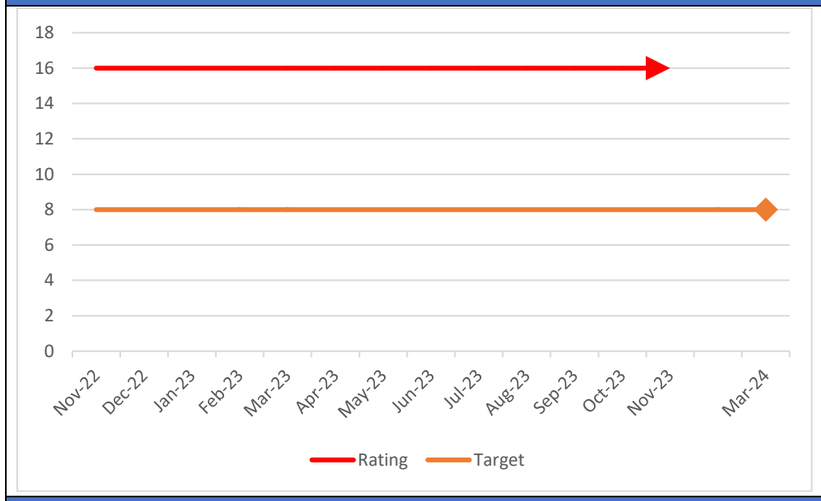
ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CMO (no. tbc)
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Paul Gilluley
	✓	✓	✓	✓			Responsible committee	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)	November 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 which will be discussed with the Chief Transformation and Strategy Officer (CTSO) and Chief Medical Officer (CMO). 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

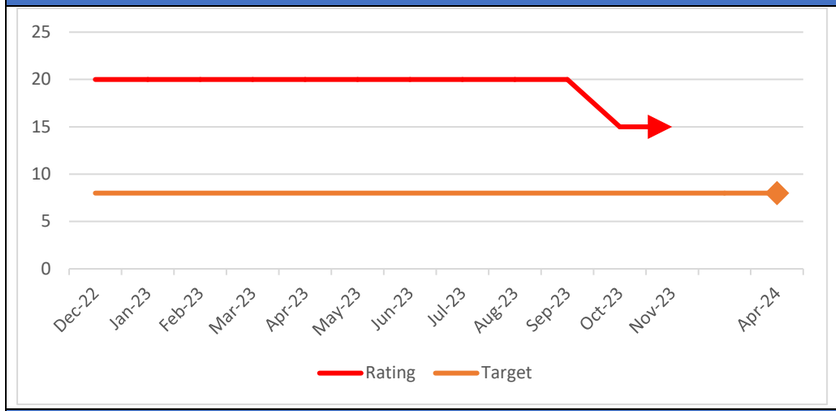
ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO11
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Charlotte Pomery
	✓	✓	✓	✓			Responsible committee	Population 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)	November 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.	Complete
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**
	15 (5x3)	November 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
Staff in NEL ICS have access to Freedom To Speak Up/ Whistleblowing/ Guardian services to raise concerns regarding quality and safe care.

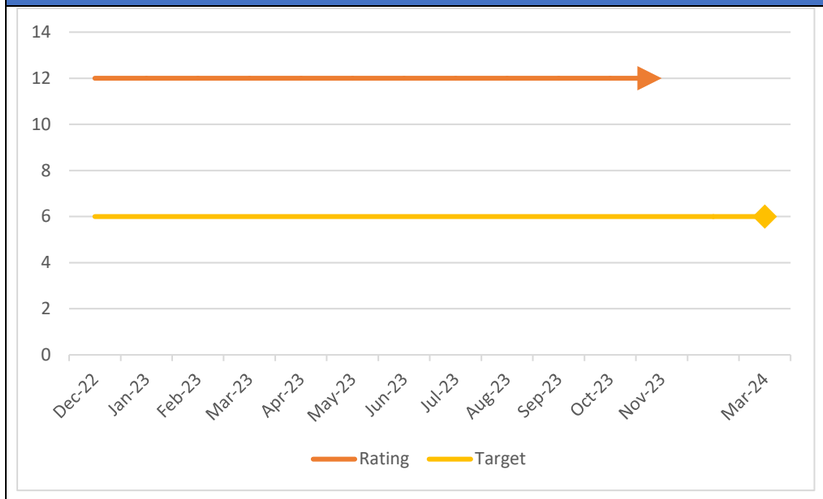
Mitigations/ actions to address the risk	Target date
Escalation discussions taking place across London Chief Nurse network and Chief Medical Officer network - also replicated across NELHCP Monthly London Clinical Executive Group	Ongoing conversations
After Action Review and Clinical Harm Review processes to be determined – done through Provider quality Meetings	Ongoing
Provide Trust, Clinical huddles, Ops huddles and Quality and Patient Safety huddles take place across each hospital site daily. Issues feed into ICS System meetings. Some Trust also have nursing workforce daily hub discussions.	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 and planned for Feb 24 meeting**
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

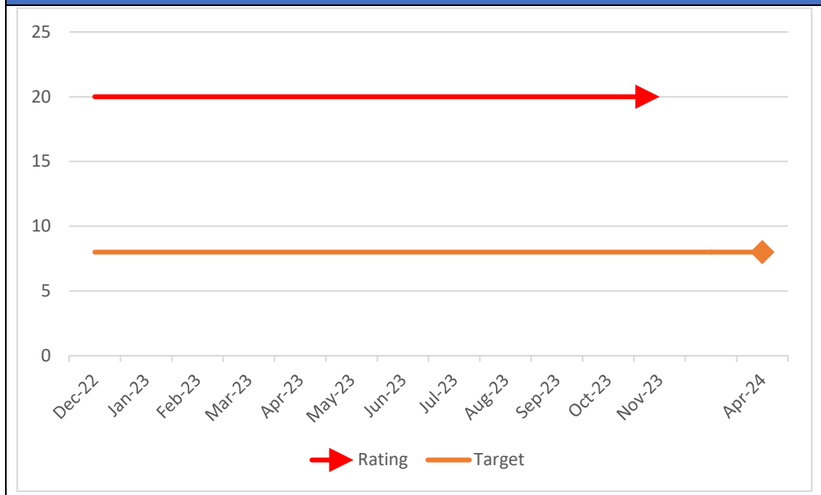


Initial rating (LxS)	Initial date	Rationale
12 (3x4)	December 2022	Given our current service requirements and workforce pressures, that cuts across organisations, if we do not plan and deploy effectively we will not be in a position to deliver the range of services required. And, may impact on the health 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)	November 2023	The strategy document is in the process of being finalised, for sign of in January 2024. Funding is still to be secured to turn the aspirations into actions, that impact on residents' lives. Engagement has taken place 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. Engagement with our residents at Place has also taken 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 during the course of November, December and January.

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	Complete.
Set up a task and finish group to develop and agree a minimal employment offer and flexible deployment of staff	March 2024
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

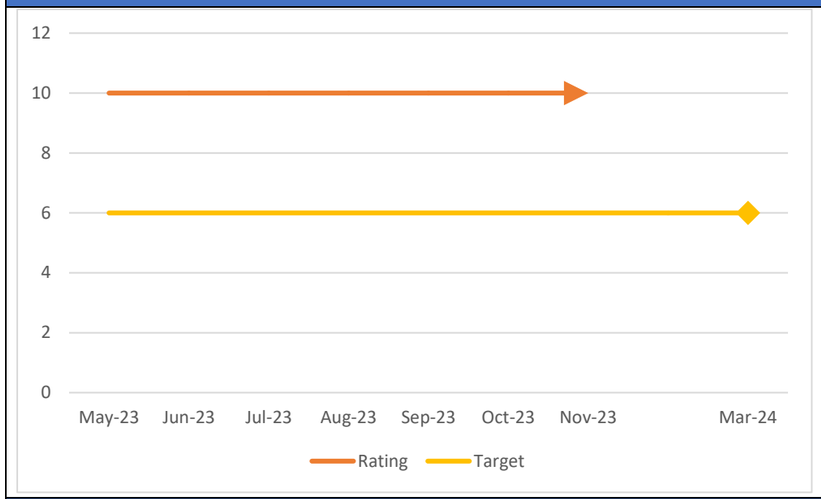
ICS Aim	To tackle inequalities in outcomes, experience and access							Risk applies to ICB	Risk applies to ICS	Risk reference	CNO (no. tbc)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Diane Jones
	✓		✓		✓		✓			Responsible 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 (2x4)	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)	November 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
Interim ICB Director of Nursing and Safeguarding commence in Dec 23. Substantive role out for recruitment

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**

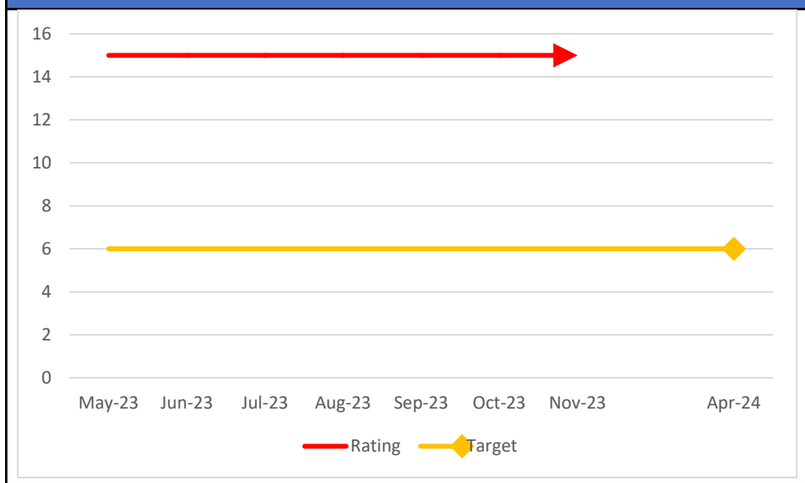
ICS Aim	To enhance productivity and value for money							Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO02
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Johanna Moss
	✓		✓		✓		✓			Responsible committee	Finance, 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)	November 2023	A meeting with Julian Kelly took place on 9 October 2023, where the ICS had 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.	Complete (October 2023)
NEL wide Infrastructure strategy required by NHSE will review options and priority areas for investment to enable better future planning of investment and spend.	March 2024

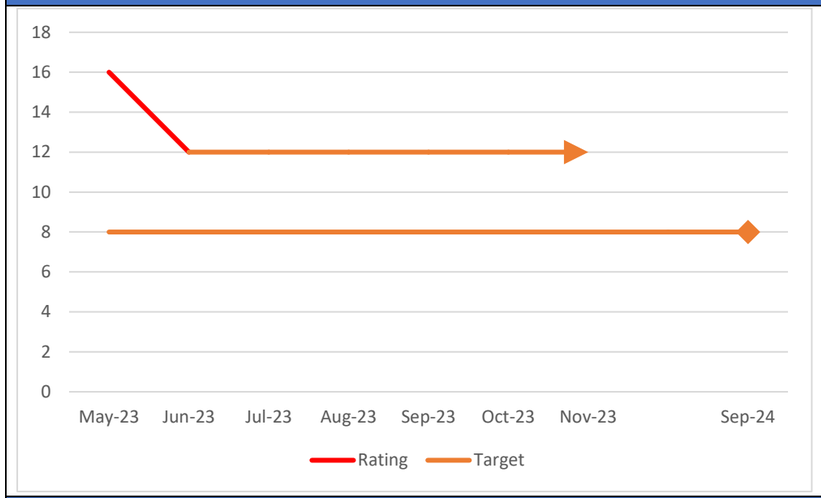
ICS Aim	To enhance productivity and value for money							Risk applies to ICB	Risk applies to ICS	Risk reference	CFPO14/ CFPO15
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Henry Black
	✓		✓		✓		✓			Responsible committee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

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**15 (3x5)**	May 2023	There is current experience of co-operation on the 23/24 Operational Plan with shared financial accountability. The exit criteria or the SOF4 status for BHRUT have yet to be clarified. The domain with the highest likelihood of poor outcomes is UEC, where the NEL system has been designated as Tier 1, requiring the highest level of intervention and support.
	Target rating (LxS)	**Target date**	**Rationale**
	6 (3x2)	April 2024	Expectation to deliver UEC recovery plan in the context of Tier 1 designation. Learning from Winter 22/23 to be applied.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	15 (3x5)	November 2023	Recent revision of cancer care standards is now being monitored in shadow form. Reduced risk of activity underperformance on planned care due to continued medical staff industrial action (IA), but waiting list has grown and is 10% over trajectory. National study to assess effect of industrial action and potential harm for patients has not concluded. Revised planning assumptions for 2023/24 issued by NHSE on 8 Nov 2023, and assurance to be provided by ICB and Trusts by 22 Nov 2023.

Controls and assurances
North East London Cancer Alliance in place and leads on NEL cancer performance and delivery.
Monthly/weekly reviews of all areas are in place along with project governance.
Acute Alliance in place for NEL to address the acute delivery through local clinically led recovery programmes, reviews of strategy and approach based around High Volume, Low Complexity (HVLC) care and robust operational oversight and challenge supported by the regional team
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 HVLC 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. Monthly trajectories track progress against the six mandated metrics aligned to the national programme for winter planning and delivery.
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
The FPIC will extend its scrutiny to patients awaiting treatment in Community Services

Mitigations/ actions to address the risk	Target date
NHSE-led review of BHRUT SOF 4 status with clarification of exit criteria for finance and UEC	10 Nov 2023
A review of the 22/23 Winter plan has been undertaken to ensure improved safety of patients in 23/24 and incorporated into the current Winter Plan	Complete – Nov 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.	Complete - August 2023
Governance arrangements for UEC have been considered by the UEC Programme Board	14 Nov 2023
Revised planning assumptions for H2 2023/24 issued, with assurance process for Trusts and ICB, including Quality Impact Assessment	22 Nov 2023

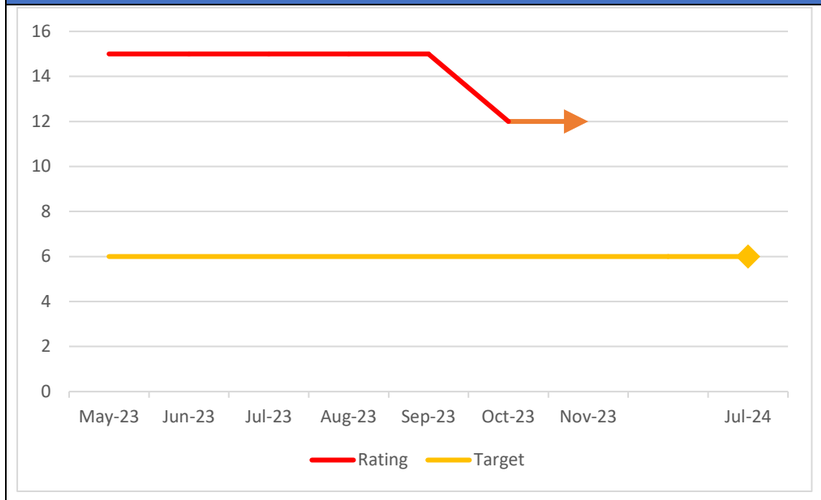
ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO13
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Charlotte Pomery
	✓	✓	✓	✓			Responsible committee	Population 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)	November 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. Dental, Optometry and Pharmacy Services (DOPS).

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**
	12 (3x4)	November 2023	Good progress has been made at our anti-racism North East London workshop and the work from this will continue in the right direction There are no 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

29 November 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 meeting of the Executive Committee held on 9 November 2023. The key items detailed in the report include: • Deep dive into cancer • North East London Integrated Care System (ICS) people and culture strategy • Delivery plan for recovering access to primary care • Financial recovery overview
Action required	Note
Previous reporting	None – this is an exception report from the meeting held in November 2023.
Next steps/ onward reporting	The committee meets again on 11 January 2024 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	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 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 meeting of the Executive Committee held on 9 November.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 In November the committee welcomed a deep dive report into the cancer pathway which is also being discussed at today's Board meeting. The report highlighted the work being undertaken across all elements of the pathway including prevention, awareness and screening, diagnosis, treatment, support for people living with cancer, and end of life care. Members highlighted the importance of anchoring this work at a place level and including in the system planning cycle in order to see any variance in outcomes within communities, which would identify any inequalities. The committee also discussed how data on the wider determinants of health, such as childhood obesity and smoking cessation, could be triangulated into the Cancer Alliance's work and prevention workstream.

2.2 The committee reviewed the draft Integrated Care System (ICS) people and culture strategy; the final version of which will be presented to the ICB Board at its meeting in January. The strategy will create a shared vision for what we want to achieve together for the north east London health and care workforce as an integrated care partnership. It will provide a blueprint for why, where and how we work together to deliver maximum impact. Members highlighted the importance of collecting and sharing data in order to understand what is impacting on our workforce, such as violence and aggression, pay parity, and workload. A Memorandum of Understanding will be established between partner organisations to enable the sharing of data once the specific parameters have been agreed. Innovative thinking will be required to meet the increasing demand on the system and its workforce and utilising digital technologies and artificial intelligence will be a key component to this. The financial implications and risks involved will be included in the final strategy being presented to the ICB Board.

2.3. Members received a report regarding the delivery plan for recovering access to primary care, which has been broadened to include recovery plans for urgent and emergency care and elective care for discussion at today's Board meeting. The Delivery Plan for Recovering Access to Primary Care (PCARP) was published on 9 May 2023 and sets out two central aims; to tackle the 8am rush and reduce the number of people struggling to contact their practice, and for patients to know on the day they contact their practice how their request will be managed. The delivery of the plan cannot be undertaken by primary care alone due to many interdependencies that span across portfolios; support from colleagues working in acute and community services is therefore required to ensure successful delivery. Members highlighted the need to build in capacity as well as access due to the growing demographics in north east London and the aging GP workforce. The plan will need to have a strategic approach and also include productivity in order to demonstrate whether there is any clinical variation across neighbourhoods which would highlight health inequalities.

2.4 The committee was informed of the latest financial position and discussed the letter received from NHS England which explained that in order to cover the costs of industrial action to date, the following has been agreed with the Treasury:

- Allocating a total of £800 million to systems sourced from a combination of reprioritisation of national budgets and new funding.
- Reducing the elective activity target for 2023/24 to a national average of 103%, which will now be maintained for the remainder of the financial year.

The additional funding will be conditional to the ICS achieving a breakeven position at year end and the plans to achieve this must be submitted to NHS England by 22 November. The plans must also be designed to protect urgent and emergency care, cancer and maternity activity. The committee discussed how this funding is not new NHS monies, but will be allocated from other existing funds which could potentially impact workforce and digital workstreams.

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

29 November 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 18 October 2023.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in September 2023.
Next steps/ onward reporting	The committee meets again on 13 December 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 18 October 2023.

1.2 The board is asked to note this report.

2.0 Key messages

2.1 The committee discussed the regular update report from the Procurement Group. Members welcomed the progress made in regard to clinical contracts but were

concerned about slow progress in other some areas. The committee received assurance that the concerns raised would be fed back at the next meeting of the Procurement Group.

2.2 A further update on progress relating to the implementation of the new national finance system by 1 April 2024 was received and aspects of the discussion linked closely to the update from the Procurement Group particularly in regard to Purchase Order compliance. Committee members were updated on the key issues relating to the ledger cleansing process and welcomed the support being given by the Executive Management Team in order to progress the work plan, however, the committee remains concerned about the overall risk to the ICB and the system of not having everything in place by the implementation date.

2.3 Committee members discussed risk in detail including digital risk and members were briefed on the bid recently submitted to secure resource for a system-wide cyber security approach which will bring together all the cyber security risks we have as a system and will put us in a much better position to be able to identify cyber security risks which are continuous.

2.4 An in-depth discussion took place in regard to the significant financial challenges faced by the system particularly in regard to sustainability. Members welcomed all the action being taken in regard to the financial recovery program and welcomed the membership being system-wide. Concern about the fragility in each of the local authorities within north east London was discussed and a high-level overview of our local authority finances was requested as part of the next finance update to ensure the committee has a clear understanding of the risks to the system as a whole.

2.5 Committee members noted progress updates from our External Auditor, Internal Auditor and our Local Counter Fraud Specialist.

3.0 Risks

3.1 Achieving 100% compliance on the use of purchase orders for all future procurements, which needs to be in place for the 1 April 2024. Progress is being delayed by the impact of the restructure which still not complete.

3.2 Achieving the required financial outcomes is still a significant concern as performance is slipping in a number of areas including Cost Improvement Plans (CIPs). There is also a risk of under-performance this year affecting the next financial year.

3.3 Risks considered at committees and the strategic risk register are not yet fully aligned with examples from the Quality, Safety and Improvement Committee. There is a danger of gaps arising in the risk register.

3.4 The risks arising from cross contamination generally among system members and in relation to cyber security may be emerging issues.

3.5 Risks in relation to year end value for money reports will need to be balanced with the requirement for quality outcomes.

Author: Cha Patel, Audit and Risk Committee Chair
October 2023

North East London
Integrated Care Board

NHS North East London ICB board

29 November 2023

Title of report	Workforce and Remuneration committee exception report
Author	Anna McDonald, Senior Governance Manager
Presented by	Diane Herbert, Non-executive member
Contact for further information	anna.mcdonald@nhs.net
Executive summary	This report provides an overview of the items discussed at the meetings held on 3 October and 30 October 2023.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in September 2023.
Next steps/ onward reporting	An exception report will be presented to the board going forward.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	Employment and workforce – to work together to create meaningful work opportunities and employment for people in north east London now and in the future.
Impact on local people, health inequalities and sustainability	The Committee will receive assurance on the ICB's Employment Flagship Priority, ensuring that we utilise the ICB's ability to provide meaningful and positive employment opportunities for local residents.
Impact on finance, performance and quality	The Committee and all of its members are bound by the ICB's Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB.
Risks	The Committee will be driven by the organisation's objectives and the associated risks and its duties will be governed by the Terms of Reference. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

1.0 Purpose of the report

1.1 The purpose of this report is to provide an overview of the agenda items discussed at the committee meetings held on 3 October and 30 October 2023.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The committee received a progress update on Phase 2 of the ICB's change programme and following the meeting, an updated detailed Equality Impact Assessment for the ICB's new operating model was shared with the committee. Further updates on Phases 2 and 3 will be provided over the coming months.

2.2 The committee received a presentation on workforce productivity in north east London based on detailed analysis undertaken with provider colleagues across the system. The discussion generated a number of questions in relation to data integrity and the need to ensure that providers supply accurate data.

2.3 A helpful update on clinical care and professional leadership (CCPL) was noted.

2.4 The ICB's chief executive and chief officer objectives were discussed and approved by non-conflicted members of the committee together with the reporting process for performance appraisals. A further update will be presented to the committee after the end of the financial year.

2.5 An extraordinary meeting of the committee was held on 30 October in order for the committee to consider the ICB's voluntary redundancy scheme. The scheme has been jointly developed in partnership with Staff-side and management and uses the learning from NHS England's voluntary redundancy process as the baseline. The committee discussed the scheme in detail and approved it in advance of the proposed launch date of 6 November 2023.

3.0 Risks and mitigations

3.1 The duties of the committee will be driven by the Integrated Care System and organisation's objectives and the associated risks.

3.2 The ICB has had significant financial constraints applied to its operating income. The ICB must address every opportunity to reduce recurrent expenditure. The voluntary redundancy scheme may enable us to reduce the number of compulsory redundancies that may be necessary.

Author: Anna McDonald, Senior Governance Manager
31 October 2023

North East London
Integrated Care Board

NHS North East London ICB board

29 November 2023

Title of report	Quality, Safety and Improvement (QSI) Committee exception report
Author	Dotun Adepoju, Senior Governance Manager
Presented by	Imelda Redmond, Non-Executive Member
Contact for further information	dotun.adepoju@nhs.net
Executive summary	This report provides a summary of the key items from the meeting of the Quality, Safety and Improvement (QSI) Committee held on 18 October 2023. The key items detailed in the report include: • Review of the QSI terms of reference • Review of strategic risks • Quality highlight report • Paediatric audiology • Primary care • Quality scanning • Safeguarding policy papers
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	The Committee next meets on 7 December 2023 and a regular exception report will be presented to the Board.
Conflicts of interest	There are no known conflicts of interest
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To 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 the QSI committee the greatest risks noted are: • those related to tackling inequalities in outcomes, experience and access. • the Continuing Healthcare (CHC) digital systems procurement process has been paused.

1. Purpose of the report

1.1. This report provides the Board with an overview of the items discussed at the Quality, Safety and Improvement (QSI) committee held on 18 October 2023. 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 reviewed its terms of refence focusing on membership and proposed changes to include additional attendees.

2.2. **Risks and Mitigations:** The committee welcome a deep dive review of the strategic risk register. It was noted that there is a need to agree what level of risks should be presented to the committee and what risks are held elsewhere within the organisation. The committee advised that strategic risks should be determined against the attainment of the set objectives of the ICB. There is a need to understand the risk management process used at the different levels within the system so that the committee can have an understanding of why items are listed in the risk register presented at meetings.

2.3. The committee received a verbal update on quality exceptions with regards to three issues.

2.3.1. Following the National Quality Board Risk and Issues escalation procedure, a formal letter has been written to Richard House, a children's hospice based in Newham informing them that the NHS North East London will now work with them through an enhanced surveillance approach to seek a range of assurances.

2.3.2. Cygnet[1] has been moved from enhanced surveillance level to routine surveillance and has informed NHS North East London that it will be closing Hansa Ward, a low security ward for female mental health patients. NHS North East London does not have any patients on the ward but we are working in our role as a host commissioner with all placing commissioners, NHS England (London) and NHS England North West England (who hold the contract) to ensure all patients are safely transferred to other locations and their families are appropriately informed.

2.3.3. NELFT was placed under enhanced surveillance based on its Section 28 Coroner's report, which was based on a lack of actions completed and no evidence of learning being embedded. Additionally, the ICB has informed them of a range of quality and safeguarding concerns and we will be seeking assurances for these areas through the same enhanced surveillance approach i.e. monthly assurance meetings.

2.4. The committee received a report on paediatric audiology and highlighted concerns. Service issues identified by NHS England (NHSE) include lack of clinical governance and oversight, poor reporting of data, poor interpretation of results, poor retention of diagnostic data, and lack of accreditation with UK Accreditation Services (UKAS), Improving Quality in Physiological Services (IQIPS) which provide evidence of quality management and delivery systems for the CQC and other purposes. The committee was informed that the task and finish group is aware of the situation and are monitoring it and provide regular feedback to the Chief Nursing Officer. As there

[1] Cygnet Health Care is an independent provider of mental health services which operates over 150 centres with more than 2,500 beds across the UK.

is an overlap between performance and quality, the committee will receive the NEL performance reports at its meetings going forward.

2.5. The committee received a deep dive into primary care. It noted the national context for primary care transformation, the challenges of delivering sustainable services to our local people, the current scale of primary care and the way our population access appointments, experiences and recent patient survey information, the work underway to improve primary care services, and recruitment and retention in the workforce. The committee noted that whilst the report was solely on General Practice, future reports on dentistry and optometry would be useful too.

2.6. The committee received a quality scanning report which provided updates on (i) NHS System Oversight Framework and recent enforcement guidance published by NHS England, (ii) NHS Annual Assessment approach and findings from the NEL ICB 2022/23 Annual Assessment and (iii) Progress on the work of the Delivery and Continuous Improvement Review, including NHS IMPACT. NHS IMPACT is a single improvement approach published by NHS England. An accompanying self-assessment tool has also been published. The committee will maintain this as standing item at future meetings but acknowledged that there would be meetings when there would be no updates available for the committee.

2.7. The committee received and approved four 2022-23 annual safeguarding policy papers and one declaration paper. These were: (i) NEL Safeguarding standards 2022-25, (ii) NEL Safeguarding supervision policy 2022-25 (iii) NEL Safeguarding Adults and Children Policy 2022-25, (iv) NEL Domestic Abuse Policy and Procedures 2022-25 (v) NEL Safeguarding children declaration 2023-24

Dotun Adepoju, 27 October 2023

NHS
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NHS North East London ICB board

29 November 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 30 October 2023, to discuss the following business: • Variation of spend in Continuing Healthcare across Place • A detailed discussion on the Mental Health Investment Standard • Month 4, 2023-24 Performance Overview • Month 6, 2023-24 Finance Report • Variation of section 256 agreements with local authorities in Barking, Havering and Redbridge • Updates from the Financial Recovery Director • The Chief Finance and Performance Officer's Risk Register • Updates from Committee sub groups
Action required	The Board is asked to note the report.
Previous reporting	None – this is an exception report from the October 2023 Committee meeting.
Next steps/ onward reporting	The Committee next meets on Thursday 30 November 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

1.1 The last meeting of the Finance, Performance and Investment Committee (FPIC) took place on Monday 30 October 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 was updated on the workstreams underway to deliver £15m in efficiency savings in the Continuing Healthcare (CHC) budget by the end of 2023/24. Progress to date has been limited due to the time required to start new projects and the impact of the staff consultation exercise. Discussions focused on how best proposed workstreams might be supported to ensure that planned in-year financial savings are achieved while promoting strong clinical leadership and linking to similar change projects underway across north east London (NEL). The committee recognised the changing demographics and needs of the population across NEL, particularly the increasing over 85 population that marked a change from the historically young NEL demographics. The committee welcomed the steps being taken to commission services at scale and reduce the variations and lack of standardisation in CHC decision making at Place, including moves towards closer working with local authority partners. The committee remain concerned about the scale and the pace of the change required to achieve the planned savings and will continue to monitor progress through the recently established Financial Recovery Board (FRB).

2.2 Committee members were briefed on the investment of Mental Health Investment Standard (MHIS) funding totalling some £120m across NEL over the last five years, and the outcomes achieved in terms of improvements, service transformations and mobilisation of new services to fill unmet needs. Committee discussions centred on benchmarking spend and outcomes in NEL against other ICBs and where any potential further investment could be most usefully aimed to reduce system pressures and support partners and local people. Positive improvements and outcomes across many services were recognised, along with the role of the Mental Health, Learning Disability and Autism Collaborative in bringing partners together. The Committee asked that a version of the circulated paper be made available for

discussion in partnership forums to further develop effective investment proposals. The mental health services team was also asked to continue to work with the acute and mental health providers in NEL and the FRB on initiatives underway to ensure that patients requiring mental health services are seen and cared for in the right environment.

2.3 The committee was briefed on Month 4, 2023-24 clinical performance across the NEL providers. This included the growth in planned care waiting lists that had risen above trajectory in July 2023, while the numbers of very long waiting patients continued to be low. This growth in waiting lists was attributable to the consultant and junior medical staffing industrial action (IA) earlier in the year and in October 2023, which had led to a loss of elective capacity and contributed to the failure to meet the revised national requirement to treat all patients waiting over 78 weeks by 30 June 2023. The IA has also impacted performance in other areas, including diagnostics, as available staff have had to be re-deployed to other areas. The number of patients waiting more than 62 days for cancer treatment was now falling but Barts Health NHS Trust remains in Tier 2 for cancer services and subject to increased NHS England (NHSE) oversight. The NEL system is being supported in Tier 1 (highest risk) for Urgent and Emergency Care (UEC) services for 2023/24, with monthly meetings between NEL, NHS England (London) and the national team. The committee discussed the mitigations being put in place to improve performance and requested the expansion of the performance report to cover community and primary care services, along with the ability to explore data split by provider or place.

2.4 The committee received the Month 6 (September), 2023-24 Finance Report, which highlighted a year to date adverse variance to the operating plan which was £5.4m behind the trajectory for the Financial Recovery Plan (FRP), which is forecast to deliver a year-end system deficit of £54m and which was yet to be formally agreed by NHSE. The committee considered the factors that were adversely impacting on the delivery of operating plan and the FRP, including IA, inflation and the difficulties in achieving planned efficiency savings in prescribing and continuing health care costs and the use of agency staffing across the system. Discussions centred on the mitigations to the most significant risks, in particular the direct costs of IA, and indirect costs in relation to the loss of elective recovery funding (ERF). The committee welcomed the appointment of a Financial Recovery Director and the establishment of the system-wide Financial Recovery Board (FRB) to identify and drive forward opportunities for improvement through closer partnership working across the NEL Integrated Care System in the short and medium term and bring the system into financial balance. However, the committee recognised that the FRP in place would become more challenging to deliver in the second half of the year. The committee was also updated on ongoing discussions with the national NHSE team to look at potential support for local capital expenditure, although any support was likely to arrive late in the financial year.

2.5 The committee agreed to vary section 256 agreements with the London Boroughs of Barking and Dagenham, Havering and Redbridge to bring the lead commissioning role for virtual wards back from the local authorities to the ICB, along with the associated funding. This will allow the services to be mobilised in time to support the winter response.

2.6 Updates from committee sub groups were received from the Primary Care Contracts Sub-Committee, Business Case Assurance Group and Procurement Group and were noted.

3.0 Risks and mitigations

3.1 The committee received the latest finance and performance directorate risk register in October 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: 08/11/2023

North East London
Integrated Care Board

NHS North East London ICB board

29 November 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 25 October 2023.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in September 2023.
Next steps/ onward reporting	The committee meets again on 6 December 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 25 October 2023 and this exception report outlines the key messages and actions taken by its 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 Chair reopened the action regarding how the different elements of the system are working together and also ensuring that there is effective communication between committees, as this has been a common theme among several committees. Members suggested that it would be beneficial to develop a process map to clearly demonstrate how information should be shared.

2.2 The Committee approved a proposal for the first two years' allocation of the shared ambition fund which will be used for a commissioned service from community pharmacists, with a focus on the promotion of health and wellbeing, access to clinical pharmacy advice and support to the most vulnerable residents to self-manage their minor ailments, where the current cost of living pressures may impact on their ability to purchase medication when required. The Selfcare Advice Service will provide local residents with clinical advice for managing their minor ailments or signpost to other integrated services which form part of the community pharmacy clinical framework e.g. hypertension case-finding, smoking cessation, or pharmacy contraceptive services. It will also provide additional benefit by confirming community pharmacies as accessible clinical services for residents, providing health advice, supporting health promotion and the prevention of ill-health and providing links to other local services including immunisations. As well as access to clinical pharmacy support, the scheme will provide access to medication for the most vulnerable residents across North East London to self-manage their minor ailments, where the current rising cost of living may impact on their ability to purchase medicines.

Members suggested that the key performance indicators are reviewed in order to ensure suitable metrics are used which demonstrate how inequalities will be reduced and recommended that a further report is presented one year into the initiative to review performance and outcomes. The committee also recommended that targeted communications to those who meet the eligibility criteria are in place to ensure that the right people are aware that this is available to them. As the service is for vulnerable residents on a low income, it will be important to factor in that many may not have access to the internet or smart devices to receive information.

2.3 Members welcomed a report which set out our growing understanding of the extent and nature of population growth in north east London and its impacts. It demonstrated that the current NHS funding models in place are will not fully respond to the pace and size of population growth in north east London and described the groundwork needed to agree how we might respond to improving the health and wellbeing of local populations in this context. The committee recommended that the report is brought to a future meeting of the ICB Board to discuss further and this has been added to the agenda for today's Board meeting.

2.4 The Committee reviewed the risks on the Board Assurance Framework and the discussion was welcomed by members and reflected points raised at other committees of the ICB Board. The committee highlighted that the nature of the strategic risks it holds responsibility will only be achieved in the longer-term and instead asked that annual targets be set for mitigating actions that would enable us to track progress towards longer term achievement. This would create momentum and a dynamic approach, allowing for changes within risks. It was noted that the appetite for all risks on the BAF was 'Cautious', which is not necessarily reflective of north east London's current position and recommended that the appetites are reviewed by the ICB executives and committees of the Board. The committee also recommended that responsibility for the risk regarding working with ICS partners, stakeholders and local communities is reassigned to the Population Health and Integration Committee, rather than to the ICP Committee, as a sub-committee of the ICB Board.

2.5 The Committee received updates from its sub-committee representatives and were informed that in preparation for the Metropolitan Police's launch of 'Right Care, Right Person', partnerships have been working with mental health Trust colleagues to ensure there is support for vulnerable residents. The meetings taking place in north east London with borough commanders have not been initiated elsewhere in London, which is a positive reflection of our partnership working. It was also noted that the

modular units for the new community diagnostic centre at Barking Community Hospital have arrived on site and that the centre is expected to open in Spring 2024.

3.0 Risks and mitigations

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

Author: Katie McDonald, Governance Manager
Date: 27.10.2023

NHS
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Integrated Care Board

Integrated Care Board Forward Plan

	25-Jan-23	29-Mar-23	31-May-23	23-Jun-23	26-Jul-23	27-Sep-23	29-Nov-23	31-Jan-24	27-Mar-24	XX/05/2024	XX/07/2024	xx/09/2024
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												
Organisational values and behaviours												
Finance and Performance												
Overview report												
2023/24 budget												
Assurance												
Board Assurance Framework												
Quality												
Deep dives		Urgent and emergency care	Mental Health		Health inequalities	Primary Care	Cancer	Specialised services	Babies, children and young people	NHS community services and virtual wards	Urgent and Emergency Care	Long term conditions
Quality report												
Annual complaints report												
Strategy												
Integrated Care Strategy												
Roadmap on integration												
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												
Access Recovery Plans												
Flagship priorities												
Supporting equit and sustainability (population growth)												